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PSYCHOTHERAPISTS' EXPERIENCES OF PATIENT SUICIDE

by

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A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

2002

This manuscript has been read and accepted by the Graduate Faculty in Clinical Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

9/9/02
Date

Chair of Examining Committee

9/11/02
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Abstract

PSYCHOTHERAPISTS' EXPERIENCES OF PATIENT SUICIDE

By

Hilary J. Rubenstein

Dissertation Advisor: Professor Larry Gould

50% of psychiatrists and 35% of other mental health professionals experience the suicide of a patient during the course of their career (Chemtob, 1988). Yet, few case studies of patient suicide have appeared in the literature. This study uses the recollections of ten therapists to study treatments of patients who committed suicide.

A pattern emerged from the treatments studied. Therapists felt an immediate positive connection with the patient early in the treatment. The hypothesis derived from this study suggests that idealization and omnipotence dominated the transference and countertransference in these treatments, leading the patient and therapist to feel excitedly hopeful in the early phases of treatment. Although patients improved to some degree in most treatments, the therapists felt hopeless in the later phases of the treatment and doubted that the patient could benefit from further analytic exploration. Yet, they could not imagine terminating the treatment because the patient was seen as too impaired. Most therapists handled this dilemma by turning towards a solely supportive approach with the patient. They sought to help the patient avoid intolerable states of mind in general, and intolerable negative transference states in particular. Although a positive rapport was maintained with the patient, it will be argued that avoidance of intolerable states of mind is an interminable, impossible pursuit that breeds disillusionment and hopelessness in both therapist and patient and undermines the task of psychoanalytic work. In the treatments studied, none of the patients shared their suicidal intentions with the therapist prior to the suicide. Both therapist and patient had lost faith in the analytic process as potentially helpful. It will be suggested that hope could only be renewed through the analysis of hopelessness.

This study does not provide definitive explanations the patients' suicides, nor does it suggest that another intervention could have prevented the patient's suicide. Detailed clinical material is presented to illustrate the themes of idealization, omnipotence, hope/hopelessness, intolerable experience, and the physical and emotional availability of the therapist. Three contemporary perspectives on analytic involvement (Freudian, relational and Kleinian) are presented to provide a theoretical framework to discuss the findings of this study.

Acknowledgements

I am deeply grateful to my senior colleagues who contributed their clinical experiences of patient suicide for this research project. Had they not given so much of themselves in terms of time and thoughtful reflection, I could not have gathered such meaningful results. I am very grateful for their contribution to me as a researcher. However, I feel what I gained most from the process of interviewing participants, I gained as a clinician and as a human being. As a junior therapist, I had such a unique opportunity to study a treatment with them and learn from their clinical experience. I admired their courage in sharing such a difficult experience, and their courage in revisiting the treatment. Whether or not this research contributes to the field, it has had an enormous impact on me that I believe will make me a better clinician.

I began this project several years ago after a patient of mine committed suicide. I am so thankful for the support of those around me at the time whose love, guidance and willingness to listen allowed me the opportunity to respond creatively to a traumatic experience in the form of this dissertation. I would to like to acknowledge several of those people individually for the specific role that they played in the process. Dr. Larry Gould, the chair of my committee, showed unwavering confidence and trust in me that allowed me to gain confidence in my ability to make this project successful. He showed an uncanny knack for intuiting the balance of autonomy and instruction, friendship and mentoring I needed. My growth and development continues to be greatly enhanced by his steady presence. Dr. Steven Ellman provided two kinds of inspiration for this project. On a concrete level, he taught a theoretical framework that I was able to use to analyze the data. But more importantly, he inspired me through his respect for patients and deep commitment to psychoanalytic work. His trust in the analytic process serves as a model for me as a therapist and a patient. I cannot thank him enough for this precious gift. Dr. Steven Tuber supported me enthusiastically from my first interview at City to the defense of this dissertation. I am privileged to have been his student.

Dr. Peter Kaufmann played multiple roles in this project. As a reader, he provided contributed greatly to the theoretical basis of this dissertation. As a clinical supervisor, he provided consultation when my patient committed suicide and then went on to supervise me through the difficult process of going-on-being as a clinician. I was so fortunate to know him in all these roles and would like to thank him especially for keeping me related. Other supervisors were tremendously helpful to me during this time and I would like to acknowledge them, Dr. Laurie Levinson, Dr. Dodi Goldman and Dr. Stephen Solow. In addition, Dr. Elliot Jurist, served as a reader on this dissertation, contributing a thoughtful and fresh perspective during the final countdown to the defense.

In addition to my teachers and supervisors, I had the privilege of remarkable colleagues during my time at City. Most of all, I have relied on John Grienenberger as a friend and confidant from the first day of orientation until today. I have also felt fortunate to have the friendship of Liz Bernbach and Monica Grandy. I look forward to many more years as colleagues and friends.

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CHAPTER 1

INTRODUCTION

"Patient and therapist view the dimension of time quite differently. To the therapist time is an ally, allowing better understanding, opportunity for change and so on. To the suicidal (hopeless, despairing, ideationally constricted) patient, the idea that time is forever is an oppression. Time is the enemy, promising only more torment." (Berman, 1992)

This is a retrospective study of therapists' experiences of patient suicide. To gain a deeper understanding of what happens in cases of suicide, I interviewed therapists in depth about their experiences of patient suicide. Thus, time is not only an ally to this study, time is a luxury of this study. Time provides the luxury of reading extensively on the subject, talking at length to colleagues and teachers, gathering the experiences of multiple therapists, creating hypotheses, rejecting hypotheses, and revising hypotheses. Time provides the luxury of taking breaks from this study when one cannot contemplate the subject matter any longer. A study is a safe playground, a place to be creative and a place to make mistakes with little consequence, a place to exercise "twenty-twenty hindsight" ruthlessly. In other words, a study of this nature has all kinds of luxuries that clinical work does not have.

I tried, in this study, to learn from therapists' experiences of patient suicide and to gain clinical wisdom from their recollections. But, analyzing data is not comparable to analyzing a patient and trying to help someone in distress. Even if this study lives up to my greatest expectations, and uncovers some "truths" of "what goes wrong" in cases of suicide, this study will at best add one more piece of clinical knowledge to what I take into the consulting room. Back in the consulting room, we are bound to reinvent the

wheel with every patient. In fact, we should reinvent the wheel if the treatment is to be alive, creative endeavor.

This is a retrospective study of therapists' experiences of patient suicide. I took advantage of the luxury of time and the knowledge of the suicide outcome, to learn something more about the clinical phenomenon. By interview, I asked the treating therapists to reflect on the patient, the treatment and the suicide. Each therapist was asked to share what he felt he learned from the experience of this particular patient. The therapist and I considered what happened in the case. In addition, the therapist and I considered the impact the suicide has had on their professional development.

The Importance of this Study

Volumes of literature exist on the phenomenon of suicide in the areas of philosophy, religion, literature and psychiatry. Within psychiatric literature alone, the literature on suicide is vast. But relatively little has been investigated about suicides in the context of an ongoing psychotherapy relationship. One study estimates that up to 28% of people who commit suicide were either in a psychiatric treatment or had recently terminated treatment (Litman, 1965). Other studies suggest that 30-50% psychiatrists and other mental health professionals experience a patient's suicide (Chemtob, 1988). And yet, I found only four first-person accounts of patient suicide and only another handful of clinical studies of patient suicide.

The Dilemmas of this Study

As I began to think about studying the cases of patients who commit suicide while in treatment, I came up against some of the dilemmas that may have hampered research in this area. I came up against resistance to this research, from myself and from those I

consulted about the potential project. As an introduction to this study, I would like to present some of the most basic challenges of this study.

1. **"Nobody is going to talk to you."**

Most therapists I spoke to about this study felt that I would not find an adequate subject pool to complete this study. Psychotherapists who have lost a patient to suicide do not usually write about the case or present it for several reasons. The suicide can be considered a mark on the therapist's professional record. The therapist may also feel unable to discuss the case amongst colleagues because the patient's confidentiality would be jeopardized or surviving family members could be further upset. Therapists may not feel comfortable openly discussing possible mistakes in the treatment or even passing doubts about the treatment, for fear of surviving family members' anger or litigiousness. But in a sense this is an obvious dilemma, an important problem in an impossible profession like psychotherapy. This is a dilemma in every field of medicine where a treatment that can heal could also harm. How can we learn if we cannot openly discuss mistakes?

More importantly, an enormous amount of shame and secrecy surrounds the suicide of a patient. I knew one risk to this study would be that I would not find any subjects. Confidentiality would need to be guaranteed. I hoped some therapists would want to contribute their experiences if they felt adequately protected from professional risk.

2. **"It won't be generalizable."**

Although many therapists experience patient suicide, (Chemtob, 1988), therapists rarely experience more than one suicide in their career. No matter how great the impact on their professional development, they may feel their experience to be idiosyncratic and feel unable to make general statements about patient suicide.

In my study, I faced this dilemma by bringing together multiple cases for consideration. Intensive interviews allowed for common themes to develop. Hypotheses were generated and hypotheses suggested in the theoretical literature were further examined.

3. **"You're not going to learn anything about the patient. You are just going to learn about the therapist."**

Could we learn anything clinically useful from the limited data of the therapist's recollections? Without the collaboration of the deceased patient, could we confirm or reject the therapist's hypotheses about the suicide? Could an outsider look at the therapists' recollections and hypotheses and offer anything more about the case?

I felt sure that the therapist, a full participant in a relationship with the patient, would have a lot to say about their experience with a patient who suicided. My pilot study suggested that I would in fact learn relatively little about the patient, but I would learn an enormous amount about how the therapist felt being involved with the patient. Classical psychoanalysis viewed the analyst's presentation of a case as the primary method for learning. Under the classical paradigm, the analyst could "objectively" talk about the patient.

Many contemporary psychoanalytic theories suggest that the success of an analysis depends on how a particular dyad works together, not on the diagnosis of the patient. Under this paradigm, the therapist's subjective experiences of the patient could be considered very valuable clinical data, if not objective data.

4. **"You are not even going to learn anything about the therapist. You are inquiring about the worst moment of their professional career."**

What could we learn about a particular therapist from their experience of one case that was likely to have been the most difficult in their professional life? Could the therapist tell us about the impact of the suicide on their professional life? Were they aware of it themselves? This study captured no more than a snapshot of the therapist at a particular moment in time after the suicide.

5. **"You are going to get a totally skewed sample. The only people who are going to be willing to talk to you will be people who still have a lot of unresolved feelings."**

This was the most disturbing of all the dilemmas I encountered. I am sure that the sample I got was skewed in important ways that I will try to make sense of. However, the judgmental attitude that underlies this statement has kept suicide and therapeutic failures in the closet since the dawn of the practice of psychotherapy. I assume that in any treatment, especially an incomplete treatment, the therapist has unresolved feelings. I also assume that when a patient suicides under the care of a psychotherapist, the therapist has feelings about the patient for a long time. Who talked to me and why remains an

important question. The therapists may have had overt or covert agendas in participating in this study. This variable could not be avoided. The therapist's reasons for participating in the study will be examined as a part of the data.

6. **"Why are you doing this dissertation?"** Of all the dilemmas of this dissertation, this dilemma was by far the most personal and challenging. What was my agenda? I promised myself that I would work towards an adequate answer to this question by the time I completed this dissertation. My only answer at present is, "time." This dissertation bought me a lot of time to work through my own experience of a patient's suicide that took place in April 1998. The reverberations of that experience into my life did not stop, only quieted. The experience of my patient's suicide helped and hindered this study, in all likelihood. I paid close attention to the interaction of my own experience with the experiences of the subjects in my study.

What can I hope to learn from this study?

Undoubtedly, we can never know with certainty what happened that brought these patients to taking their lives. However, I suspect that with the luxury of time and twenty-twenty hindsight, we will always be able to come up with some hypotheses of how the psychotherapy relationship may have been involved in the suicide. In fact, I expect most therapists entered the interview with thoughts about the role of the therapy in the suicide. These "theories" entered the dialogue as conscious hypotheses about the suicide or unconscious fears about the role of the therapist played in the suicide. In my dialogue with the therapist, we collaboratively considered any theory of the suicide the therapist

held and struggled with the complexity of evaluating the role of therapy in such a final and self-destructive act. My belief is that the struggle itself yielded fruit. In other words, the issues that came up repeatedly in competing "theories of the case" showed us where we need to focus.

I am **not** guided by a framework that suggests that the psychotherapy can be the causative factor in a suicide. More accurately, I believe that the patient's transference (which, for the moment, I mean broadly as the patient's way of relating to the world, not just the therapist) will be at the center of each suicide. Thus, I reviewed the literature on transference and countertransference enactments to lay the groundwork for a perspective where the suicidal act may be viewed as meaningful in the patient's psychological and relational world.

Questioning the role the therapy relationship may have played in a suicide is clinically useful whether, at the end of this examination, we feel we know definitively what happened in the case. The therapist may feel his understanding evolved over time. During the interviews, new insight may have evolved. And inevitably, I had new insights as I analyzed the data and compared therapists' experiences to one another.

CHAPTER 2

LITERATURE REVIEW

I. INTRODUCTION TO THE LITERATURE REVIEW

This study is based on the psychoanalytic understanding that suicide is an action that takes place within an individual's intrapsychic and relational world. When a patient suicides in treatment, the therapist is a player in that patient's intrapsychic and interpersonal world. Thus, the suicide is assumed to have a meaning in the patient's inner life and a correlating meaning in the relationship to the therapist. The act of suicide can be seen as a communication of a meaningful aspect of the patient's psyche. The suicide is also a communication in the context of a specific moment and dynamic of the transference.

To evaluate the meaning of the patient's suicide is impossible, because the analytic collaborator (the patient) is deceased. The patient offers no further explanation of his actions, no affirmation or rejection of subsequent interpretations. Only one half of the collaborative analytic pair is left to sort through the data available. The therapist's ability to gain understanding of the suicide is limited in several ways. The therapist is the recipient of a transference communication that is likely to be complicated, multi-determined and inchoate. More importantly, the therapist had a relationship with the patient. The loss of the patient is a real loss and can be devastating personally and professionally. The therapist may have unconscious and ambivalent feelings towards the

patient. Thus the therapist has been abandoned by his collaborator, left with a complicated task of sorting the patient's transference communication from the therapist's conscious and unconscious feelings about the patient, the treatment, and the patient's death.

This literature review must provide a guide for approaching the recollections of the therapist after a suicide. To create such a framework, I will present four areas of literature:

1. the theory of action and enactment of the transference in psychoanalysis
2. contemporary perspectives on the analytic involvement
3. psychoanalytic and other major conceptualizations of suicide
4. the impact of the suicide on the therapist as a person and a professional

The goal of this study is to observe and participate in the process whereby therapists search for the patient's communication, sorting through their own reactions and evaluating the treatment. This process of sorting through and working through is a critical piece of grief work, but particularly important to a therapist who goes on working with patients. How does the therapist work through a patient's suicide? How do they work through the failure of the case? How does this working through process affect their ongoing practice of psychoanalysis? How do they come to understand the suicide? Is anything learned from the experience? These are the exploratory questions of this study. These are the questions I asked the analyst to reflect on.

I am guided by a theoretical framework where the patient's suicide is seen as a meaningful communication in the context of the therapy relationship. Each theoretical

orientation within psychoanalysis has a theory of how action is meaningful in the context of psychoanalysis. I will review the history of the concept of action and the current debates about action in the psychoanalytic literature. I will review the concepts of acting out, countertransference, enactment, interaction and projective identification. In this section, I will review the various papers that have been written about suicide in treatment. These papers are all written with the perspective that the act of suicide is a meaningful act in the context of the therapy relationship.

In addition to the literature on action in psychoanalysis, I have chosen to review three contemporary perspectives on the analytic involvement. This literature allows us to contemplate not only the manifest content of the suicidal enactment, but the context of the suicide in the analytic process. From this perspective, we can ask, 1. What was going on in the total relationship? 2. Where might the analytic process have gotten derailed? 3. Did one or both parties give up on the analytic process?

If an understanding of the analytic involvement allows us to look at the analytic process, then the literature on suicide allows us to look at the fantasies that underlie suicide. I will look at the basic psychoanalytic conceptualizations of suicide. Most theories of suicide are written from a one-person, intrapsychic model that looks at the dynamics of individuals that suicide, not the relationships of those who suicide, although the relationship is usually implied. A review of this literature examines the core suicidal fantasies. I will focus primarily on psychoanalytic conceptualizations of suicide, but I will also specify the major contributions of cognitive and biological perspectives.

Finally, I will review the brief literature on the impact of suicide on therapists. Research on the overall impact of suicide, research on the impact of suicide on therapists

and first-person accounts by therapists will be covered. The goal of this section will be to highlight the struggles that therapists go through after a suicide. This section is meant to provide a better understanding of the therapist-subjects who will participate in this study.

Overall, the literature review will provide a lens through which to view the post-suicide reflections of therapists.

II. THE CONCEPT OF ACTION IN PSYCHOANALYSIS

Action in psychoanalysis has been a topic of discussion since Freud. Freud believed that action and ideation were mutually exclusive and that analysis could only occur in a context where the patient's actions were frustrated. The production of analyzable material, thought and fantasy, relied on the frustration of action. At the same time, Freud (1914) saw transference as an active kind of remembering, a way that the patient acted out the past without consciously remembering it. The goal of treatment, from this perspective, is to interpret the transference, bringing action-memory into ideational (conscious) memory. Sandler (1976) says that transference is not just the patient's perception (or misperception) of the analyst, but it is the patient's activity towards the analyst. It is the patient's active attempt to get the analyst to play out a role.

Since Freud, action took on an increasingly negative connotation in analysis (Aron, 1996). "Acting out" became a negative term referring to the patient's anti-communicative resistance to the analytic task, where the patient acts out transference wishes with others outside of the treatment. "Acting in," a term coined by Zeligs (1975) is then distinguished from acting out as communicative actions of the patient within the

analytic sessions. But Aron (1996) points out, both "acting in" and "acting out" are descriptive classifications of the patient's behavior. These terms exist in the context of a one-person psychology where the analyst is an observer of these behaviors.

"Acting out" came to be viewed as a diagnostic symptom of patients with a high narcissistic need, an intolerance of frustration, exhibitionistic tendencies and a belief in the magic of action. (Greenacre,1950). Greenacre (1950) saw it as characteristic of patients with earlier disturbances, preverbal disturbances and disturbances of communication. Throughout psychoanalytic history, patients diagnosed with earlier and more severe disturbances were likely to be deemed "unanalyzable." Inevitably, "acting out" patients were (and are still) likely to be deemed unanalyzable. A. Freud (1936) implied that habitual acting out could not be understood or analyzed.

The danger of the patient's actions was addressed early on by Freud (1895) who recommended that patients make no major life decisions during the period of analysis for fear that patients would make poor decisions under the sway of powerful transference states. Greenacre questioned the utility of prohibition of action, stating that the analyst cannot know in advance what the patient will put into action, and that by its nature, "acting out" is ego-syntonic. Thus, it will not be perceived by the patient as self-destructive at the time of the action's commission. The same questions of patient's actions, prohibition and analyzability are all present in current debates. Patients who are often considered likely to act, particularly to act self-destructively are presumed to be more difficult, less analyzable or needing special modifications and controls of their analyses (Kernberg, 1987). Other contemporary analysts see action from the patient with more compassion. Action can be seen as the way the patient begins to remember and

bring into the analysis the transference (Boesky, 1982). In this sense, action can be seen as a positive sign of the patient's deepening involvement in the treatment. Does "acting out" then become actions that make the particular analyst subjectively uncomfortable? Current theories have moved away from discussion of the objective meanings of particular actions. Analysts now focus on the patient's communication to the analyst via action and the analyst's participation in the dyad.

Countertransference:

As ideas developed about the actions of the patient under the sway of powerful transferences, ideas developed about the actions of the psychoanalyst under the sway of powerful countertranferences. Freud discouraged activity on the part of the analyst. He was concerned that the cure in analysis not be based on the suggestion, advice or influence of the analyst, but come from change within the patient (Ellman, 1998). He required that analysts not take advantage of the patient's transference, prohibiting physical contact, particularly sexual contact with patients. The analyst was the neutral, objective observer and interpreter of the patient's unconscious conflicts. But, Freud implied that the analyst is prone to reacting to the patient and the impulse to action must be monitored and restrained.

It was understood that to fulfill the goal of neutrality, the analyst had to be fully analyzed himself. Countertransference, in the classical sense, was defined as the analyst's unconscious thoughts and feelings about the patient derived from the analyst's unanalyzed unconscious conflicts. The analyst's conflicts were thought to induce un-analytic actions from the analyst. Countertransference was considered an obstacle to

treatment, something to be discovered, analyzed and eradicated. Yet, consideration of one's countertransference was tantamount to admitting one was not adequately analyzed (Aron, 1996). Freud's desire to make analysis a more mechanistic scientific procedure led to a position where thoughtful examination of countertransference may have gone underground (Ellman, 1998). In addition, Freud's limited statements about counter-transference suggest tremendous anxiety about the danger of the analyst's feelings towards the patient. He writes to Jung:

"I gather that neither of you has yet acquired the necessary objectivity in your practice, that *you still get involved*, giving a good deal of yourselves and expecting the patient to give something in return. Permit me, the venerable old master, to say that this technique is invariably ill-advised and that it is best to remain reserved and purely receptive. *We must never let our poor neurotics drive us crazy*. I believe an article on counter-transference is sorely needed; of course we could not publish it, we should have to circulate copies amongst ourselves." (out of Gabbard, McGuire, 1974, pp.475-476, italics mine)

Gabbard (1999) suggests that Freud's anxiety about countertranference was taken seriously for several decades but have gone "largely unheeded in contemporary discourse on psychotherapy and psychoanalysis." I disagree with Gabbard. There are many indications in the literature that while it is now considered acceptable to have feelings towards patient, there is still a lot of anxiety about analysts feeling "too much" for patients. For example, after an explanation of erotic countertransference feelings that implies that they are normal, acceptable, and analyzable, Kernberg (1989) states that analyst should refer a patient out if they experience early, intense erotic feelings for a

patient. Kernberg's assumption is the same as Freud's; intense countertranference feelings put the analyst at risk for losing behavioral control. Both suggest that intense feelings on the part of the analyst cannot be analyzed. However, numerous analysts have said it is just this intense emotional involvement from the analyst which gives the analysis therapeutic potential. Winnicott, Searles and Little all advocated that the analyst must indeed "go mad" with the patient and then contain it for the analysis to have an effect on disturbed patient. Boesky says, "if the analyst does not get emotionally involved sooner or later in a manner he had not intended, the analysis will not proceed to a successful conclusion" (Boesky, 1990, p.573) Similar perspectives on the analyst's emotional involvement have been voiced by other contemporary analysts (Renik, 1993, Maroda, 1999).

Further evidence of contemporary anxiety about countertransference feelings can be seen in the current vociferous debate on countertransference disclosure that will not be discussed here. Gabbard, who discarded Freud's statement on countertransference as a product of his bygone era, goes on to recommend that when an analyst is forced to disclose countertranference, the analyst should disclose his "dilemma" to the patient by stating, "Either way I answer the questions could lead to significant problems for the therapy. If I say that I do not find you attractive, you may feel devastated. If I say, that I do, you may feel that the therapy is not as safe a place as you previously thought." Gabbard portrays the analyst as anxious that revelation of his feelings could lead to "significant problems for the therapy." The anxiety Gabbard portrays speaks to the same anxiety as Freud's; the analyst's feelings can destroy the treatment. Without going into an excessive analysis of the meanings this statement could have to the patient, we could at

least say that the statement implies that 1.The analyst's feelings can be dangerous and destructive to the treatment 2. The analyst and patient might not be able to be talk about or analyze these feelings without acting on them 3. The analyst must protect the patient from knowing these feelings. All the while analysis as a method implies supposedly that 1. Feelings in and of themselves cannot destroy. 2. Any feeling can be talked about and analyzed. 3. The neurotic patient suffers from protecting himself from the emotional truth of his own feelings and other's feelings. Patients must at some point come to terms with their analyst as a human being, capable of sexual and sadistic arousal and capable of self-control. Analysts want to avoid intense countertransference feelings and disclosure of intense countertranference feelings, to avoid the possibility of enactment.

Racker (1957), whose writings focused specifically on countertransference, understood that analysts were more like their patients than they were willing to experience, constantly struggling with similar conflicts and anxieties. He suggested that countertranference presented "the greatest tool and the greatest danger" to psychoanalytic treatment, thus identifying with both sides of the debate. Yet, he experienced the analyst's intense feelings towards the patient as unavoidable. He viewed the psychoanalytic community's avoidance of countertransference as based on analysts' retention of their infantile ideal in their persona as analyst. Analysts rejected, repressed and denied their countertransference to live up to this ideal. In his opinion, generations of analysts completed analyses, but were left with unresolved issues of guilt about their infantile wishes, because they retained a belief that their infantile ideal was still attainable and embodied by their own analyst. In other words, they had come to accept their infantile wishes *as patients*, but as adult/ analyst, they remained unconsciously identified

with infantile ideals. Thus, they were likely to be excessively defensive with their own infantile wishes even as they encouraged patients' acceptance of their own infantile desires.

Unproductive outcomes of the analyst's excessive defensiveness would likely follow. For example, the analyst denies his own aggressive feelings towards the patient, while he is asking the patient to acknowledge the patient's aggression. The analyst's intolerance of his aggression communicates intolerance of the patient's aggression. The analyst leans towards being identified with the rejecting parent and as a result the patient's aggression is heightened and directed towards the rejecting parent. The optimal stance, therefore, would be the analyst's awareness of the evoked infantile wishes and his recognition of his identification with the patient. To do this, he must recognize his idealized vision of himself as adult analyst as an unattainable ideal and de-idealize himself as analyst.

Writings on acting out and countertransference all imply the possibility of enactment in the interaction between two persons with an unconscious. From a variety of theoretical perspectives, there is a basic consensus that the analyst's self-analysis is useful to the analysis, while ignorance or denial of the analyst's unconscious is dangerous to the analysis. Greenacre (1950) believed that the analyst could unconsciously encourage the patient to act out the analyst's inhibited wishes. Searles (1958) went further in work with psychotic patients to show how patients' hallucinations can embody repressed elements of the analyst's unconscious feelings towards the patient. Implied in these works is that *developmental conflicts are ubiquitous human experiences and inevitably analysts will continue to struggle with the same conflicts as patients*. Thus, they are likely

to be constantly identifying with different aspects of patient's conflicts. The advantage, says Racker (1957), is the analyst has more practice at maintaining an objective stance towards his subjectivity. Racker insists that the difference between patient and analyst is not that one is sick and one is healthy, but the analyst has been practicing the method of self-analysis for a longer period of time.

Interaction, Enactment, and Projective Identification: When Transference and Countertransference feelings go into action

Freud (1914) describes the psychoanalyst as in "a perpetual struggle with the patient to keep all these impulses which he (the patient) would like to carry into action within the boundaries of his mind." Freud suggested that the struggle was to keep the impulses in the realm of ideation. Contemporary conceptualizations view the struggle as the effort to stay with the analytic task. Influenced by analysts like Racker and Searles, countertransference feeling is seen as ubiquitous. It is generally accepted that the analyst has constant thoughts and feelings about the patient. Contemporary analysts focus on how this can enlighten or impede the analytic task.

Furthermore, contemporary conceptualizations acknowledge that the psychoanalytic situation is inherently frustrating for both patient and analyst. Both parties must deal with frustrated wishes in the deprivation of the analytic relationship. This deprivation can evoke earlier object relationships and regressive behavior from the analyst as well as the patient. (McLaughlin, 1991; Chused, 1991; Maroda, 1999) The goal is no longer seen as the eradication of the analyst's wishes and feelings towards the

patient, rather, it seems to be the continuation of the analytic task in the presence of frustrated wishes (Bacal, 1996). The terms interaction, enactment and projective identification have been used by relational theorists, contemporary Freudians and Kleinians respectively to describe the interplay of the patient and the analyst's psychologies and behaviors. Although each theoretical orientation addresses the analyst's conscious and unconscious feelings towards the patient and their conscious and inadvertent behavior towards the patient, analysts differ widely in determining what is useful to the analytic task. Notably the same questions come up across theoretical lines. If the analyst's countertransference is at least partly unconscious, how can the analyst definitively determine when it is at play? If the analyst considers all of his responses as potentially originating from either the patient or himself, could this lead to blaming the patient for the analyst's unconscious conflicts? Is an inadvertent or unconscious feeling that is acted on a mistake? Is enactment anti-analytic, pro- analytic or neutral? Who determines what is in the service of analysis and what is counter to the analytic task?

The interpersonalists took on the interplay between the analyst and the patient's psychologies and behavior from the outset. They believed that the analyst's presence, his particular personality and his choice of intervention influenced the patient from the beginning of the treatment. The term "participant-observer" came to represent an interpersonal model of the analyst's stance with the patient. Contemporary relational theorists have explained that the stance is not a prescription for certain actions from the analyst. It is a "recognition of the inevitability of participation and of the need to observe the effects of this participation on the analytic process" (p.194, Aron, 1996). Thus, from the relational perspective, the entire treatment is an ongoing enactment. Both transference

and countertransference are jointly created phenomena. The goal of any given moment in treatment is to become aware of the current enactment and the roles of the participants in creating that enactment. Awareness of the enactment allows for the current enactment to be transformed only so that the next series of enactments can begin.

One relational analyst who has written about more severe levels of acting out in analysis is Davies (1996). She believes that once a treatment has begun, the patient's acting out always has a transferential component, no matter where the action occurs. Without examining how the action relates to the analyst, the treatment will not move forward, particularly in the case of self-destructive behavior. With severe cases of acting out, analysts are likely to shy away from transference interpretations that Davies believes are crucial to addressing self-destructive behavior. A perspective of projective identification (which will be discussed later in terms of Kleinian theorists) is used to understand how the therapists ability to think and to perform the analytic task can be impaired during certain transference and countertransference dynamics. Many relational theorists assume that the analyst's psychodynamics will inevitably become involved in enactments because the analyst will inevitably identify with the patient's self or object representations. Maroda (1999) states that the goal is that the analyst's psychodynamics play a supporting, not a starring role in the enactment. This perspective implies that patient and analyst struggle with similar conflicts; overidentification or complementary identifications are inevitable and must be subjected to analytic scrutiny.

Freudians have used the terms "actualization," "role-responsiveness" and more recently, "enactment" to describe the moments in the treatment where the patient and or analyst bring into action a dynamic from the patient's inner world. Although some

analysts have added that it can be the analyst who initiates the enactment (Ellman, 1998), it is mostly considered a manifestation of the patient's inner life. The difference between the Freudians writing on this topic and the relational model is that the enactment is considered to be at least, non-analytic, if not anti-analytic. While many Freudians have cited the inevitability of enactments, there is still a goal of avoiding enactments in so far as possible. The interplay is seen, at best, as a compromise formation between the role the patient is forcing on the analyst and the analyst's tendencies or "role responsiveness" (Sandler, 1976). Unconsciously and imperceptibly, the patient and analyst slip into roles that are familiar to them. When noticed, examined and explored, this role-responsiveness can lead to a deeper understanding of the patient's conflicts. A view of enactment as more anti-analytic would be when the enactment is seen as a moment where the therapist is impaired in analytic functioning by a loss of narcissistic equilibrium (Ellman, 1998).

All the divergent views under the Freudian umbrella focus on the central question of whether the interplay eventually results in something that moves the analytic task forward, hinders the task, or solidifies into a more permanent impasse that prohibits the task. Action has no value of its own. The question is whether the action becomes a fixed repetition or a flexible, re-creative, transformed event that can be understood and used analytically. The one Freudian who diverges from this explicitly is Renik (1998). He believes that the analyst must feel free to respond spontaneously to the patient. He must trust that he can analyze his participation and effect on the process after the fact. Renik places a positive value on spontaneous action, explicitly freeing the analyst from the history of shame associated with countertransference and enactment. He encourages the analyst to be more fully available to participate and examine his participation in the

analytic process. Along the same lines, Chused (1998) suggests that "it is written into our job description that in 'doing analysis' we must contain ourselves, yet still experience the impulse to action. But when actions are forbidden, often the experience of the impulse also feels forbidden...it may be more useful for an analyst to act on an impulse, catch himself, and thereby learn about the impulse and its stimulus, than to be so constricted that he is never stimulated or so defended that he is not aware of his behavior (p.94)."

Object relations theorists have examined action in psychoanalysis through the lens of the concepts of internal object relationships and projective identification. "Actualization" is the interpersonal externalization of an internal object relationship (Ogden, 1986). The internal object relationship contains a self-representation and a representation of the object, both of which are a part of the patient's ego.

The concept of projective identification provides another framework for understanding action in psychoanalysis. Projective identification, like transference, is the interpersonal externalization of an internal object relationship, with the two important additional components: pressuring the external object into identification with a role and fantasizing control over the experience of the external object. The patient's ego splits off one aspect of the internal object relationship (either the self-representation or the object-representation) and then pressures the external object to become identified with the split off aspect of the object relationship. There is a controlling attempt to make the external object experience how the internal object experiences itself and perceives the self (Ogden, 1986). Projective identification is accompanied by the fantasy of getting rid of unwanted parts of the self and putting them into the external object in a controlling way.

Projective identification is considered a ubiquitous process and a necessary part of the treatment relationship. The analyst must identify with the projected aspects of the ego in order to experience the patient and interpret. Ideally, the analyst identifies with the projected aspect of the self, is aware of the identification, and uses the identification as understanding to further the analytic task. This is likened to the mother's facilitative developmental role of containing the infant's projections, metabolizing them and eventually returning them to the infant in a less toxic form.

Projective identification can lead to action and enactment in two ways. The analyst can identify with the projected aspect of the patient without awareness of the identification and can act out the role of the patient's internal object. This situation can lead to a repetition of the patient's internal object relationships where the patient experiences himself as omnipotently controlling the analyst as if he were a mental object. Alternatively, the analyst can refuse to identify with the patient's projections which can lead to the patient feeling rejected and misunderstood or abandoned and left alone to contend with noxious internal objects (Rosenfeld, 1987). In both situations, the analyst loses the ability to experience and simultaneously reflect on the patient's projections.

Freudian, relational and Kleinian analysts look at the process of action in analysis through their particular theoretical lens. Underlying the various stances is a perspective that the analyst must be very involved and identify with the patient's projections or experience the impulse to enact the patient's inner world in order to really understand the patient. Simultaneously, the more involved the analyst is, the more prone to enactment the analyst will be. Thus, theorists from each theoretical orientation struggle with the

question of what furthers the analytic task and under what circumstances the analyst loses the analytic capacity.

III. ENACTMENT IN CASES TO SUICIDE:

In the next section, I will present the clinical and research data that specifically looks at what happens in the treatment of patients who commit suicide. Underlying even the most extreme views is the perspective that psychotherapy cannot cause or create a suicide, but can be more or less effective in preventing a suicide.

First Person Accounts

Very few psychotherapists write about unsuccessful cases and even fewer write about unsuccessful treatments that end with the suicide of the patient. In a search of the literature, I found only four articles written by psychotherapists about a suicide in their own practice (Levinson, 1972; Gorkin, 1985; Foster, 1987; Campbell, 1995). In addition, I found one article written by four psychotherapists. Each had a patient commit suicide during internship or residency training (Kolodny etal., 1979). These personal accounts focused mostly on the impact of the suicide on the therapist and the process of working through the traumatic experience. But, the authors also hypothesized about things that might have gone awry in the treatment. Foster considers idealization of the analyst and inevitable disappointment, as well as the patients' reactions to the therapist's vacations. She reflects on uncomfortable feelings of withdrawal, distance and deadness that she felt in the last sessions with the patients. These feelings were not understood as communications of suicidality until after the patient's suicide.

Gorkin (1985) discusses the importance of examining any unconscious negative countertransference feelings, particularly hostility. After the suicide, working through

these feelings is done to benefit the therapist's personal process of grief and his ability to continue his work, but it may also provide clues to failures in the treatment. In his case, Gorkin felt that at moments, the patient may have experienced the therapist as not concerned while the therapist was experiencing an aloof kind of withdrawal from a frustrating patient.

Campbell (1995) emphasizes the interaction between the therapist's unconscious wishes and the patient's transference. He feels he allowed external improvements in the patient's life to help him defend against and deny his wish to retaliate against the patient by ignoring the suicide risk. In his case, the patient was accidentally discovered and saved. Analyst and patient were able to analyze the meaning of the suicide attempt. Campbell (1995) analyzes the important way in which his unconscious countertransference confirmed aspects of the patient's transference. In this particular case, the countertransference confirmed the patient's belief that his father was rejecting and would not intervene in the pathological relationship with a murderous mother. The analyst may take on the role of the executioner (Asch, 1980) or the non-intervening, accomplice bystander. Campbell (1995) is employing a method of self-analysis where he examines his countertransference to see if the patient's transference has in fact become a reality in the treatment relationship.

Countertransference Hate

The management of countertransference hate is considered particularly important in the treatment of more disturbed and potentially suicidal or violent patients (Winnicott, 1949, Rosenfeld, 1987 Searles, 1958, Maltsberger and Buie, 1973). Experts in suicide

who analyze multiple cases of completed suicides are interested in how the patient may experience the therapist's hostility towards the patient. Whether the therapist's hate or fear is derived from his own unconscious conflicts or the patient's provocations, it is considered counterproductive to the treatment only when the therapist is unable to recognize it (Winnicott, 1949). Some patients may need to provoke their analyst's hate because the patient can only tolerate fully experiencing hate in the transference when he has experienced the analyst's ability to hate him (Searles, 1958). The analyst who can be open to his feelings of hatred while maintaining an empathic stance towards the patient can analyze the meaning of the hatred in the relationship. The analyst shows the patient that hate is only temporal and only a feeling, that it can be fully experienced by the analyst without destroying the relationship.

Negative countertransference can be "the greatest tool or the greatest danger in a treatment" (Racker, 1957). The analyst's awareness of the negative countertransference is critical to preventing enactment. He must be "willing to be disturbed" by his patient, to fully experience his affect without abandoning the patient or foreclosing the analyst's emotional experience (Rothstein,1999). The danger is heightened in the treatment of suicidal patients where the relationship "is far more than a transference investigation, but it is a unique encounter on which everything, at least for the patient, may pivot" (Maltsberger and Buie, 1973).

Enactment of Countertransference Hate and the Narcissistic Vulnerability of the Therapist

Maltsberger and Buie (1973), incorporating the ideas of Winnicott. Racker and Searles, examine countertransference difficulties with suicidal patients. They presume that therapists will experience strong conscious or unconscious feelings of countertransference hate towards suicidal patients at moments in the treatment. They hypothesize that when the analyst cannot maintain an optimal, empathic stance, he is likely to act on his hate or fear with reactions of either malice or aversion. This choice point between malice and aversions presents a paradoxical dilemma for therapists who are likely to value themselves for their empathic nature.

While enactment of malice leads to sadomasochistic relations with the patient, enactment of aversion is likely to lead to abandonment of the patient. Therapists will often abandon patients in more and less subtle ways to avoid malicious enactments when the therapist cannot tolerate recognizing his hatred and sadism towards the patient. Aversive responses are more syntonic to the character of the helpful therapist. The paradox is abandonment can be more devastating to the patient, whereas malicious responses are at least experienced as an implied continuation of the relationship. Maltsberger and Buie (1973) suspect that suicidal crises take place when the patient experiences the therapist as abandoning or rejecting. Suicidal patients are also presumed to be patients who expect or even provoke abandonment. Aversive responses are considered the most dangerous enactment because they are less likely to become conscious to the therapist as they are characterized by a *lack* of responsiveness. Malicious responses are more likely to be experienced immediately by the therapist as dystonic. In two cases, Gorkin (1985) and Campbell (1995) report that the suicide took place at the

point when the analyst withdrew his vigilance of the patient's suicidality under the sway of unrecognized hostile countertransference.

Maltsberger and Buie conclude that hate is elicited in the countertransference when the therapist perceives the therapeutic work as a threat to his narcissism. This is similar to Ellman's (1998) idea that enactments occur when the therapist loses his narcissistic equilibrium and is impaired from his full analytic functioning. With suicidal patients, the therapist's narcissism is most disrupted when the patient interferes with his wishes to "know all, heal all and love all" (Maltsberger and Buie, 1973).

From this perspective, the therapist's expectations of himself play a crucial role in the treatment, particularly if the therapist equates being a therapist with being omniscient, omnipotent and all-loving. When the therapist views the patient's wishes for an ideal therapist as realistic expectations, the patient's unrealistic wishes will not be interpreted. The therapist will inevitably feel disappointed in himself and may become rejecting of the patient. This scenario is an extension of Racker's (1957) belief that the analyst is impaired in analytic functioning when he equates his analytic role with his infantile ideal. When the analyst is narcissistically injured because he cannot achieve his infantile ideal, he is unable to help the patient accept the limitations of the analyst (because the analyst has not accepted his own limitations). The analytic pair is then vulnerable to highly idealized and subsequently volatile relationship.

According to Maltsberger and Buie (1973), if the therapist tends towards omnipotence, believing he can heal all, then he equates his professional capacity to his personal worth. The patient's lack of improvement is a narcissistic injury to the therapist. The wish to heal may also be a wish that the patient was not so sick (Havens, 1965). The

analyst's wish to heal all can turn into intolerance or denial of the patient's illness or suicidality. The therapist's wishes to be savior can allow him to ignore that he is cast in the role of executioner in the patient's transference (Hendin, 1981). When the therapist believes he should be omnipotent, both therapist and patient will be disappointed in light of their magical expectations of the therapy. If the therapist tends towards believing in his omniscience, he may rely too heavily on intuition, particularly in regards to the patient's suicidality. When the therapist believes he can know with certainty or that he ought to know, he is less like to ask the patient important questions and analyze the patient's wishes for an omniscient therapist.

The third common narcissistic vulnerability of therapists lies in their wish to be steadily loving and compassionate. Countertransference hate cannot be fully experienced and utilized in the analytic process, if the therapist is unable to acknowledge his own hatred. Therapists must be able to tolerate their sadistic arousal (Maltsberger, 1999). Hatred is most likely to be enacted by the therapist's withdrawal if the therapist cannot tolerate his hateful reactions to the patient. Suicidal crises are thought to occur when the therapist abandons the patient to avoid experiencing his countertransference.

Maltsberger (1999) describes a state where both therapist and patient can become driven by abandonment anxiety, as abandonment is equated with psychic death. Under this anxiety, patient and analyst are prone to enactments to avoid abandonment. Buie (1981) has suggested that one of the central motivations for most psychotherapists is to derive a secure holding environment from treating patients. The therapist's narcissistic equilibrium can be disrupted in the analytic encounter, if the threat of abandonment is present.

Dependency and Idealizing Transferences

Other dynamics have been recognized in cases of suicide, some of which relate to the narcissistic vulnerabilities above. Overvaluation or undervaluation of the therapeutic relationship can lead to crises. When the therapy is overvalued, the therapist may fail to recognize the impact of significant life events on the patient, believing a positive therapeutic alliance is enough for the patient to live for (Havens, 1965, Wheat, 1960). Undervaluing the therapy is failing to recognize the patient's dependency on the therapist. The patient's dependency may also go unrecognized when the therapist is frightened by the patient's infantile dependency and wants to escape the intensity of the patient's neediness. The therapist may respond to the patient's dependency by abandonment or demanding a more mature dependency than the patient can maintain at that time (Wheat, 1960; Modestin,1987). Underestimation of the patient's dependency was often found in clinics and inpatient units where therapists may deny the patient's attachment to ignore the impact of institutional demands, such as reduced sessions or transfers of patient care. Training clinics, internships and residency programs often transfer patients repeatedly in a way that systemically denies patients' dependency on therapists.

Another difficulty with idealizing transferences may arise when the therapist mistakes a symbiotic transference for a positive therapeutic relationship (Stone,1988). In this kind of transference, the patient feels they have reunited with the good mother and that total gratification will ensue. When this transference is understood as a good treatment alliance, the therapist may not anticipate the patient's inevitable disappointment when the therapist does not live up to expectations of the all-providing mother. Therapists

may also ignore erotic transferences or give an indirect messages of disapproval, both if which may be interpreted by the patient as rejection (Modestin, 1987).

Bacal (1981), from a self-psychological perspective, seeks to distinguish an idealizing self-object transference from dangerous idealizing transferences. Patients who have experienced early trauma and a significant lack of good caretaking may present what looks like positive, idealizing transference. Many analysts would not interpret this transference, based on Kohut's recommendations that the idealizing transference is often a developmental necessity that will foster patient growth (Kohut, 1972;1977). Many Freudians would also not interpret idealization, because they would liken it to Freud's idea of an "unobjectionable positive transference."

The dangerous idealizing transference Bacal (1981) describes is based on a lifelong belief in a fantasy good self-object. Disillusionment in these patients can be devastating as they experience the disappointing therapist as evidence of the "real" bad parent/ therapist. Good experiences of the therapist are associated with delusion; the new relationship is dismissed as fantasy because good caretaking has only been known before in fantasy. These formulations address the therapist's ability to understand the nature of patients' dependent and erotic wishes. Recognition and anticipation of the patient's intense disappointment and disillusionment is critical in these cases.

Another perspective on the idealizing transference is espoused by Kleinians who believe that the interpretation of the idealizing transference is critical to a successful treatment. Kleinians believe that idealization occurs as a result of splitting defense mechanisms where the patient is seeking to keep bad self-object representations out of the treatment. In this conceptualization, when the idealization is left uninterpreted, bad

self and object representations will remain unaltered or more dangerously they will consolidate into more powerful bad internal objects (Kernberg).

Loss of Hope

In a review of cases, Modestin (1987) found that therapists had often lost hope in the patient's treatment prior to the suicide. The responses to this loss of hope were disparate. Sometimes the patient was abandoned or transferred. But often the therapist withdrew from the patient emotionally, and manifested disinterest in the patient's inner life and a loss of faith in the analytic method. Modestin (1987) found that therapists would resort to managing a case instead of analyzing when they had given up on the patient, sometimes even hypermanaging the patient's life in reaction formation to intense wishes to abandon the patient. The therapist's discouragement was found to be communicated in subtle shifts in the frame of the treatment (Wheat, 1960). In these cases, the therapist was often unaware of their loss of hope. Alternatively, the therapist understood their loss of hope as a reality instead of as a dynamic issue in the treatment. Thus, cases were seen where the therapist re-diagnosed the patient and deemed the patient inappropriate for psychotherapy. Shifts in diagnosis or prognosis of a patient during treatment can be regarded as countertransference reactions (Rothstein, 1999).

Struggle for Control

Hendin (1981) points out that there is no conclusive evidence that management of suicidal patients reduces suicide outcomes. He contends that patient and therapist must struggle to understand from the outset of the suicidal crisis, the patient's wish to make someone else responsible for the patient's staying alive. The essential struggle for the therapist is to continue the analytic task and resist the temptation to resort to managing

the patient's life, giving ultimatums or encouraging the patient to live for the therapy. Hendin believes that suicidal patients often believe they must live for others and that others are responsible for their life. He believes that the therapy will fail if the therapist colludes with this belief. Implied in this are Maltsberger and Buie's (1973) idea about the therapist's omnipotence. The therapist must be aware of the limitations of his omnipotence and communicate this limitation to the patient.

Summary of Enactment in Cases of Suicide

While different aspects of the role of therapy in a suicide have been addressed, most of the ideas could be understood as a derivative of Maltsberger and Buie's (1973) paper on the countertransference with suicidal patients. Their idea focuses on the intersection between the patient's transference and the analyst's narcissistic wish to know all, heal all, and love all and to be loved by all. Ideas on countertransference, projective identification and enactment provide the foundation and the continuing debate about the intersection of the patient and the analyst's wishes. Chused (1998) points out the ubiquitous vulnerability of the analyst to enactment simply by virtue of the wish to heal and to help.

In a study called Psychotherapy for Better or Worse (Strupp, Hadley and Gomes-Schwartz, 1977), the most common danger of therapy cited was that the therapeutic process fosters and stimulates the patient's hope, wishes, longings and aggression. When the therapy fails to help the patient use this stimulation in the service of the therapeutic task, disappointment and disillusionment can be experienced as a retraumatization (Balint, 1969).

IV. THE ANALYTIC INVOLVEMENT

As I reviewed the literature on countertransference, and enactment, I found that neither body of literature provided an adequate framework to analyze cases of suicide in psychotherapy. I felt I needed a better understanding of the context of countertransference and enactment. Several central questions arose. Under what circumstances, can countertransference and enactment further the analytic task? Under what circumstances will countertransference and enactment destroy or derail the analytic task? When does an enactment solidify into a hopeless impasse in the treatment?

Simultaneously, in the pilot study and in the literature on suicide in psychotherapy, I found myself struggling with certain repeated themes in cases I read about or heard about.

- the analyst's loss of hope in the patient's potential for growth.
- the analyst's loss of faith in the analytic process as a method for assisting the patient in this growth or dealing with an aspect of the patient's experience
- the patient's loss of hope that analysis would be helpful
- the patient's harboring a secret realm of experience which never enters the analysis (i.e. the patient's lack of hope that the analysis could affect these aspects of their experience)

I began to struggle to put together the theme of hope/faith in the analytic process with the danger/ potential of countertransference and enactment. Enactment and countertransference are not by themselves signs of a derailed treatment. In fact, they can

herald a deepening involvement between patient and analyst. I felt I needed a deeper understanding of the analytic involvement, to look at derailments in the analytic involvement.

As I began to read in the area of the analyst's involvement in the analytic task, I discovered that after Freud, the major theorists who wrote specifically about the analyst's involvement also happened to be those theorists who worked with the most disturbed patients (Racker, Winnicott, Rosenfeld, Searles, Little). Classic papers on countertransference, the use of countertransference hate in analysis, management of psychotic transferences and projective identification in treatment came from this group of analysts.

Instead of reviewing the classic papers, I have chosen to cover only a few contemporary theorists who are writing about the analytic involvement. Each has an understanding of how enactment and countertransference fit into the analytic involvement. I will not attempt to cover the breadth of their interests in the analyst's participation, but I will limit myself to the areas which I feel can be used to analyze the data of this particular study. It is my position that each of these models may provide a unique perspective on my data. The areas I will focus on are the creation of the analytic space, the foreclosure of analytic space, the contemplation of bad objects, the analyst's willingness to be emotionally involved and the analyst's faith in the analytic method. I will try to point out how these theories of involvement might elucidate derailments in cases of suicide.

The Analytic Involvement

"What is it in the treatment situation that will allow the patient to feel there can be room to bring up vital but secret and potentially threatening topics?...what are the conditions that have to be met with the unclassical patient that will allow him to enter treatment and eventually utilize interpretive efforts?" (Ellman, 1991, p.318)

"Rather than simply noting how the patient needs to change, a two-person approach suggests strongly that the analyst be thinking about what needs to happen in the analytic relationship to facilitate the desired change." (Maroda, 1999, p.3)

"An analytic approach that avoids addressing the patient's anxiety (particularly as it relates to the negative transference) conveys to the patient a sense that the analyst is unwilling to grapple with the anger and fear the patient is experiencing in the moment....In the initial meeting, the patient is.... unconsciously attempting to assess which aspects of himself will be left untouched by the analysis as a result of the psychological difficulties brought to the situation by the analyst. The patient is, of course, right in his assumptions that it will very likely be the limitations of the analyst's capacity to analyze the transference/ countertransference that will, to a very large degree, determine the effectiveness of the analytic process that will unfold." (Ogden, 1994, p.185)

Analytic Trust (Ellman, 1991; 1998)

The concept of analytic trust provides a way of understanding how the patient comes to believe that the analytic method will help him with his difficulties. Analytic trust is defined as "the patient's realistic perception of the analyst's understanding his world...when the patient allows the analyst to help him understand characterological transferential responses" (Ellman, 1998). The patient trusts the analyst when he perceives the analyst, not just through the unique lens of his transference, but as a new experience of being reliably and consistently understood that is different from the past. The patient trusts the analyst when he becomes willing to entertain his analyst's interpretations of transferential responses because he feels he has been understood in a way that promises to help him understand and gain more control of his life. Ellman (1991;1998) says that analytic trust is often not fully established until the end of a treatment or the end of a transference cycle.

Analytic trust is sharply distinguished from terms such as "therapeutic alliance" or "working alliance" which can be present from early in the treatment and can be based on positive transference (i.e. trust of authority or respect for the all-knowing physician). Trust based on positive transference can lead to the patient complying with the analysis, "trusting" the analyst but never discussing crucial self-experiences in the treatment. This is a critical (but probably quite common) derailment of the analytic involvement where the patient and analyst get along well but the patient is not bringing important aspects of himself into the treatment. Freud called trust based on transference, the "unobjectionable positive transference." Some analysts, argue like Ellman that a positive transference can be objectionable. Some would interpret this transference early in the treatment. However, working towards building analytic trust with a patient does not imply a model of early

interpretation of the positive transference. On the contrary, it is a perspective that discourages early interpretation in favor of creating an environment where the patient comes to feel "he can spontaneously create his own world" in the treatment and eventually bring all aspects of the patient's self into the treatment.

If analytic trust is a goal, how is analytic trust built? Ellman (1991) specifies that it can probably be achieved in a variety of ways from different theoretical perspectives. In his work, the analyst works to build the patient's analytic trust by actively creating a receptive environment where he demonstrates repeatedly his willingness to hear the patient's subjective experience and his openness to the patient's negative affect. The analyst creates an atmosphere "conducive to the expression of difficult material," particularly negative affect and doubts about the analyst and the analysis in such a way that these feelings can develop. The analyst must be a "willing container" (Ellman, 1991). The goal is to allow the patient to be able to tolerate, disclose and feel more deeply his own subjective states so that he can further explore his subjective experience and ideally, spontaneously develop curiosity about himself.

Ellman, as mentioned earlier, discourages early interpretation, from the perspective that interpretation is not useful until the patient has enough analytic trust based on the new experience that he has begun to suspect that some of his reactions to the analyst are subjective, transference experiences. Before interpretation is useful, the analyst can synthesize the patient's experiences so that the patient feels understood and show the patient how intense affect disrupts the patient's self-experience and how others are experienced as impinging on the patient. The analyst must allow the patient's experience to penetrate the analyst's affective world and for this penetration "to gradually become

perceptible to the patient." If interpretation becomes necessary before analytic trust has been built (i.e. when the patient threatens to leave the treatment or is acting self-destructively), the analyst should interpret with attention to the adaptive mechanism in the patient's behavior. By showing the patient that the analyst understands how the patient feels their behavior is the only behavior available to them, the patient may be able to utilize the interpretation without feeling attacked. Balint (1969) suggests that an interpretation is not considered interpretation until both patient and analyst agree it is an interpretation. In other words, if an interpretation is seen primarily as an act, an attack or a seduction, it is an unsuccessful interpretation even if correct. From the perspective of analytic trust, interpretations are only interpretations when the patient has felt understood by the analyst and is willing to consider his reactions as his own unique transference. Interventions prior to interpretation share a common goal to interpretation, that the intervention will be used to help patient and analyst enter more deeply into the patient's subjective experience. Interpretation eventually adds the component of making meaning of the subjective experience.

Ellman points out how analysts, particularly Freudian and Kleinian, often interpret early to insulate themselves from the patient's experience, to return negative affect to the patient or to establish themselves in the role of analyst. In other words, early interpretations are likely to be enactments on the part of the analyst. He expresses concerns about the relational perspective where he feels that the analyst may impinge on the patient, by asserting his separate existence too early in the treatment by being "real." He addresses the vulnerability of his own perspective which puts a premium on holding

and containing, by pointing out how in excess, holding and containing can inhibit the unfolding of certain transference states also.

Ellman's perspective is particularly sensitive to impingement on those patients who cannot tolerate the separateness of the analyst at the beginning of the treatment. These patients are considered particularly challenging because the analyst often feels narcissistically injured when he senses that he doesn't exist in the patient's world or goes completely unrecognized as his unique self. Out of this more extreme challenge to the analyst's narcissism, Ellman suspects that in fact most breaks in the analyst's functioning as analyst stem from a disruption in the analyst's narcissistic equilibrium.

A perspective of monitoring the development of analytic trust may be useful in examining the analytic involvement in cases of suicide. Obviously, in cases where the analyst was unaware of the patient's suicidality, we can hypothesize that central aspects of the patient's inner world were not engaged in the treatment. Secret enactments that take place outside of the treatment are indicative of more severe breaks in analytic trust (Ellman, 1991). I would add to this that enactments which take place in the treatment or are discussed in treatment imply an element of hopefulness on the part of the patient (albeit ambivalent) about the potential of the treatment. Enactments that take place in secret imply an element of hopelessness about the analyst's potential to be involved in and have an impact on certain aspects of the patient's self.

Ellman's perspective allows us to think about how aspects of the patient may be discouraged from entering the treatment. We can also examine how certain aspects of the patient may disrupt the analyst's narcissism. Thus, we can search for the point of derailment and ask, what aspects of the patient presented a challenge to the analyst's

narcissism. Analytic trust is often disrupted at each, new, deepening transference cycle. A renegotiation of analytic trust must often take place at each turn, a process which can be frustrating for the analyst and taxing on the analyst's narcissism (Ellman, 1998).

Analytic trust implies several further points which are not fully articulated, but might be examined in cases of suicide. Ellman suggests that analytic trust is bi-directional. Therefore we could examine how the analyst comes to trust the patient's participation as an analytic collaborator. In addition, analytic trust implies a faith in the analytic process that is not fully articulated. The analyst encourages the patient's deeper experience of his subjective states. The analyst can allow himself to be drawn into the patient's world as he allows the patient into his world because he believes that this deep involvement in every aspect of the patient's world can be analyzed for the patient's benefit.

Another Freudian perspective which articulates this particular point suggests that the analyst is willing to be involved with the patient, willing to tolerate deep feelings towards the patient, particularly feelings of extreme disturbance, because the analyst believes that these feelings are evidence of the patient's involvement in the analytic process. The analyst believes that the deeper the patient's involvement in the analysis, the more likely the analysis can have a helpful impact on the patient (Rothstein, 1999). Thus, the analyst can be deeply involved with the patient when his analytic trust is also based on his faith in analysis as a method. Rothstein points out analysts tendency to withdraw from involvement with patients when they experience the patient as disturbing and to resort to labeling the patient unanalyzable or labeling the patient with various other diagnostic, pejorative labels. Implicit in the case examples regarding this observation, is a sense that the analyst is often resisting identification with a disturbing aspect of the patient.

In cases of suicide, we can ask: Did the patient bring all aspects of himself into the treatment? Did the analyst feel welcoming towards all aspects of the patient's self or were there certain aspects of the patient the analyst did not want to know? Were there systematic omissions? Did the analyst believe that analysis could address all aspects of the patient's disturbance? Did certain aspects of the patient present a challenge to the analyst's narcissistic equilibrium? How did the analyst's identification with the patient play a role in their relationship?

Karen Maroda: The Emotional Engagement of the Analyst and Emmanuel Ghent's concept of 'surrender.'

Maroda's understanding of "what needs to happen in the analytic relationship to facilitate therapeutic change" is based on Ghent's concept of surrender. Ghent implies how the wish to surrender is important in the treatment relationship. The 'wish to surrender' is based on an understanding of human beings as fundamentally relationship seeking as well as gratification seeking. The human being is seen as having a fundamental impulse towards self-integration, a wish to have total faith in the other (the mother), a wish to be totally vulnerable with the mother and be cared for, as well as a wish to be wholeheartedly destructive towards the mother without succeeding in destroying her. Ghent supposes that beyond seeking gratification in treatment, patients seek (and fear) a controlled dissolution of their self-boundaries (a de-integrating force) in the hope of a new opportunity to break down false self-organization and be known, recognized and found by the analyst.

Ghent, in turn, is building on Winnicott's idea of the patient's fear of breakdown, where the patient fears the breakdown and wishes for the breakdown as an opportunity to create and transform himself. Ghent reminds us that Winnicott focused on the infant's destructiveness, not because of how destructive the infant is, but because of how often the object doesn't survive. In treatment, we focus on the patient's negative transference, because of the potential this has of destroying the analysis by destroying the analyst's capacity to hold the patient. Ghent suspects that behind masochism often lies a hidden wish to surrender. When the wish to surrender is evoked by the new relationship with the analyst, but the surrender is not allowed or facilitated, the patient resorts to a perversion of surrender, submission or masochism.

Ghent's understanding of the perversion of the wish to surrender may be useful in analyzing cases of suicide. It allows us to wonder why the patient (who may or may not have had suicidal potential for years) might suicide within the context of the psychotherapy. Is it possible that the patient's commission of the ultimate masochistic act follows a disappointed wish to surrender and be transformed that was evoked by a hopeful treatment situation? How does the analyst respond to the patient's wish to surrender? Might analysts be frightened by the patient's wish to surrender, seeing it as an aggressive act, a seductive act? What involvement does it require from the analyst to "catch" the surrendering patient?

Ghent articulates a way of looking at the patient's repetitive struggles with the bad object. The repetition manifests the patient's wish and need to come to terms with the "truth of the bad object." The patient is simultaneously struggling to maintain infantile omnipotence and to take in the emotional "truth" of the badness of the object, the badness

of the self and the horror (and potential joy) of the separate other. As Eigen (1981) points out with the recognition of these existential horrors comes the possibility of being fully alive, being transformed by a separate other, being creative with wild abandon because we recognize our creativity only destroys the other in fantasy.

Maroda furthers the concept of surrender in the analytic dyad. She conceptualizes the beginning of treatment as a mutual seduction by analyst and patient. Being an effective analyst requires that the analyst be continually willing to be affected, transformed and changed by relationships with patients. Herein lies the essential problem Maroda highlights. Is the analyst always willing to be transformed? Is the analyst always up for facing certain emotional truths yet again? Is the analyst always willing to be alive (i.e. emotionally vulnerable) in this way? While the analysis is not mutual, the analyst will likely experience some level of regression herself as she becomes emotionally involved with the patient if the involvement is successful. (This has been said by Renik and Chused also.)

The concept of surrender is used to envision how the analyst gives herself over to the experience of any manner or intensity of emotion she experiences towards a patient and works towards examining those feelings and using them for the patient's benefit. Analysts may resist the experience of emotional surrender for a variety of reasons. There is excessive shame associated with intense countertransference feelings. Maroda's model of emotional surrender reminds analysts that as humans, we cannot control our feelings, we can only control our behavior. The analyst's energy in the analysis needs to be focused on analyzing our feelings and utilizing them for the patient's benefit, not repressing or denying feelings towards patients. The analyst's defensiveness towards

their feelings is a considerable threat to the treatment. The analyst's "resistance to surrender results in perversions of surrender. For example, pacification, masochistic submission, sadism, inappropriate self-disclosure and sexual boundary violation" (Maroda, 1999, p. 58). Analysts resist emotional surrender because they equate intense emotion with a loss of control, thus surrender is seen as leading to submission to the patient's wishes or the analyst's own wishes. In addition, analysts may be frightened and ashamed of coming to terms with their own primitive feelings. When the analyst experiences emotional surrender, they may also fear being hurt, abandoned or rejected by the patient when the analyst is most vulnerable.

Maroda suggests that analysts surrender to the experience of their emotions, without giving in to their behavioral impulses. They must accept that the experience of intense emotion, the confrontation with primitive feelings, the frustration of experiencing intense feelings without acting on them and the risk of making ourselves emotionally vulnerable to patients are all part of the analytic process. Furthermore, she implies that the analyst must have faith that all manner of emotion can be experienced and can be analyzed. As Ghent (1990) points out when the emotional surrender of the patient is not facilitated, the patient may resort to masochism, whereas when the patient cannot feel the analyst's emotional surrender, they may resort to sadistic attempts to break the analyst down into submission. Maroda suggests that the classical analyst's "neutrality" will simply incite the patient to work harder to break the analyst down emotionally. Classical analysts might interpret this as the patient's pathological seeking of the submission of the analyst. Maroda would interpret the patient's effort as a wish to make meaningful emotional contact with the analyst that can be derailed into sadism when thwarted. Like Ellman,

Maroda believes that the patient must experience his emotional impact on the analyst, however, the manner in which the two theorists communicate the analysts' emotional response may be quite different.

Maroda points out that analysts may intellectually agree with her ideas, but they deny their natural resistance to surrendering to their own emotions. But what about the analyst's resistance to experiencing the patient's surrender? The patient's surrender "is not to the person of the analyst, but rather a giving over to the patient's emotional experience- losing herself to herself- within the containing framework of the analytic setting" (Maroda, 1999, p.54). But the presence of the analyst is critical and the patient will not surrender " in an atmosphere where it is feared or unwelcome."

This raises some questions in the case of suicide. What happens when the analyst is made anxious by the patient's wish to surrender and is frightened of the patient's deepening transference? If the analyst feels frightened by the patient's wish to surrender, does the analyst interpret the patient's wish to surrender as hostility toward the analyst/ analysis?

Maroda addresses some of this in her discussion of the analyst's avoidance of being experienced as the bad object. Analysts often resist being experienced as a bad object, although intellectually they may believe that the patient must experience the analyst as a bad object at some point in the treatment. The analyst's resistance to being the bad object can result in "the bad object hot potato game" where the bad object goes back and forth between patient and analyst. Often, patient and analyst collude in ejecting the bad object from the transference/ countertransference relationship and into an external figure in the patient's life (i.e. the patient's parents, spouse or boss). The analyst colludes with the

patient because of a shared wish to remain innocent and a refusal to accept her own hate, envy, sadism and desire to destroy that which she loves (a refusal to face their own "emotional truth"). When the patient cannot tolerate feelings, the feeling may be passed to the analyst via projective identification. Maroda sees projective identification for its communicative qualities, as well as its defensive qualities where the patient is asking the analyst to tolerate a feeling the patient cannot bear to tolerate.

The analyst's resistance to being the bad object is understood as the analyst's wish to remain innocent, "I do not want to be the bad object because I am still clinging to the belief that the pains in my life are someone else's fault." (p.23) When the analyst has not accepted her own parents' failures, her own "badness" and experienced a de-idealization of self and self-as-analyst, the analyst cannot tolerate being the patient's bad object. To take Maroda's point a step further, when the analyst continues to feel someone must be to blame when bad feelings arise, then the analyst will likely feel shame and guilt when the patient suffers or the relationship is disrupted. The analyst might feel ashamed for being unable to maintain empathy. These feelings of "badness" may be blamed on the patient ("she's a borderline who made me feel that") or some external figure in the patient's life ("she was extremely traumatized by her mother."). Only when the analyst can de-idealize the self, can the analyst share the patient's pain without excessive defensiveness.

Like Racker (1957), Maroda believes that the analyst's deidealization of the self-as-analyst is critical to successful work with patients. Maroda restates the essence of the analytic process, but in doing so, she stresses that we underestimate our natural resistances to emotional involvement with patients and to being the bad object in the transference. Particularly, when patients were abused by their parents, patients have

difficulty coming to terms with their parents' abuse and their identifications with their parents. Their analysts, in turn, may have difficulty being the bad object of the patient, when they cannot tolerate identifications they come to feel with the patient's abusers.

Both Ellman and Maroda focus on the resistance the analyst can have to being the object of transference. Ellman focuses on the narcissistic injury the analyst feels when he is not recognized for his unique characteristics. On the flip side, Maroda focuses on how involvement with patients confronts the analyst repeatedly with unpleasant aspects of the self.

Maroda's idea can be used to analyze the involvement in cases of suicide, by asking, What was the nature of the analyst's resistance to the involvement with this patient? Is there evidence that a wish to "surrender" was evoked and transformed into masochism? Is there evidence that the patient tried to breakdown the analyst? How did the analyst deny their resistance to being more emotionally involved with the patient? Can we trace the path of the "bad object hot potato" throughout the treatment? Did the analyst resist being the bad object? Was there something about the characteristics of this patient's bad objects that made them hard to tolerate?

As mentioned earlier, Ghent's idea of surrender and Maroda's interpretation of this idea, suggest the need for a further exploration of the analyst's fear of the patient's surrender. How often does the analyst work very hard to seduce breakthrough to the patient only to panic when the patient "falls apart?" How prepared is the analyst to become the object of the patient's intense and multiple desires? How long can the analyst withstand an intense transference without losing faith in the analysis and/or in her own capacity to love/ be empathic? Maroda points out how the patient doesn't go willingly

and easily into an emotional surrender; more likely, the wish to surrender is accompanied by an intense battle. How often does the analyst decide that the deepening of the transference is not good for the patient (i.e. not good for the analyst) and the analysis is abandoned either literally or emotionally? How does the analyst communicate when the patient's surrender is unwelcome?

Thomas Ogden, The Analytic Third, The Place Where the Transference Becomes Real for the Analyst, Where Subjects and Objects Come Alive...

My discussion of the work of Ogden will be limited to a few points. His work offers a unique perspective that could contribute to the analysis of the analyst's recollections after the suicide. Ogden provides an understanding of the concepts of projective identification, the analytic third and the analytic object, that helped me conceptualize the space in which the patient's past and present experience come alive for both patient and analyst.

An example from my pilot study may elucidate this "aliveness":

A senior analyst talked about her feelings about a young female patient's boyfriend after the suicide:

"I was afraid of him. No, I am afraid of him....he scares me. It's interesting, he scares me for the safety of my children...he doesn't even know me...I have a question

about his crazy. He is grandiose, and manic and sadistic, fine. I don't care about that. But crazy."

And later in the interview, she is answering why she wouldn't meet with the boyfriend:

"His potential towards evil frightens me....it's really my own fear of his evil. People said, 'are you afraid he will sue you for malpractice?' and I said, 'no, I just don't want to engage with him because he is going to make me feel bad.' You know. He is a disgusting person....and I don't think that is purely countertransference....I think he is an evil man and I don't give a shit about his early pathology. His family. He is evil. I don't think it is countertransference. I think I hate him because he is hateful."

Regardless of theoretical orientation, most clinicians would probably react strongly to the intensity of the analyst's feelings towards a person she had never met, an object external to the treatment. I have already stated a position (Maroda's) where passionate feelings of any kind on the part of the analyst are considered not only acceptable, but the hallmark of an intense, potentially therapeutic involvement. Maroda, however, might say that, in this case, the bad object had been collusively ejected from the treatment by patient and analyst onto the external person of the patient's boyfriend.

Ogden's theory adds a dimension to this, by providing the space, the analytic third, in which the patient's objects came to life for both patient and analyst. Like Maroda, Ogden would say that the intensity of this coming to life is an essential part of the treatment. From the moment the dyad meets, from the first point of contact, the

patient and analyst create "an analytic third', a mutually created experience of the patient's past and present internal world. The patient's past is not remembered, relived or repeated, but created anew for the first time because it takes place within the new relationship. The analytic third is experienced differently by patient and analyst; it is the vehicle through which the patient's experience can be experienced and understood by analyst and patient.

An "analytic object" is anything that becomes the carrier of intersubjectively generated analytic meaning. Analytic objects reside in the analytic third which is, in a sense, the stage for all the object relations of the patient. Analytic objects are based on shared fantasies of patient and analyst. Ogden works from a perspective where he believes that analysts and patients are more alike than different. When the analyst shares a fantasy about the patient's experience, he usually experiences an emotional resonance from his own experience.

In the example of the above analysis, the patient's boyfriend could be considered an analytic object. Both patient and analyst experience this object as alive. We know from the analyst's subjective description, this analytic object is experienced as dangerous, manic, sadistic and evil. The analyst is deeply emotionally involved in a subjective interaction with the analytic third where entire sets of object relations reside. To name a few, the patient, the analyst and the bad guy/ the insufficiently-protective mother, the endangered daughter and the bad guy/ the abuser, the abused and the witness....and many more. This analysis was certainly alive and involved, in Ogden's terms. So what happened?

As the analyst points out herself, "He (the boyfriend) is grandiose, and manic and sadistic, fine. I don't care about that. But crazy.... I think he is an evil man and I don't give a shit about his early pathology. His family. He is evil. I don't think it is countertransference. I think I hate him because he is hateful." The analyst herself seems unconsciously aware that it is not the analytic object's (the bad guy) being bad, sadistic and manic that presented an obstacle to the analysis. The obstacle lies in the analyst's feeling (which was probably shared by the patient) that the object was evil which in this case seems to mean, incomprehensible, or not available to analysis. This analytic object and the object relations surrounding this object went beyond the threshold that this patient and analyst had for their ability to look at experiences and analyze them. I think the analyst expresses this best by saying, "I don't give a shit about his early pathology." I think this could be translated as, "I am not willing to analyze this object or consider the complementary object relations around it. I will not tolerate this object or consider identifying with or empathizing with this object. I don't want to know it or find it within myself. If there is an emotional truth in this experience, I'd rather not know it."

Maroda provides a way of understanding how the analyst and patient eject a bad object collusively. But, Ogden's conception shows how the bad object was not ejected from the treatment at all. It was very much alive in the analytic third. But, the analytic object and the whole analytic third (the set of object relations surrounding the analytic object) stopped being the subject of analysis. Ogden would say the analytic third subjugated the subjectivity of the analyst and analysand. Patient and analyst became trapped in the complementary roles to this bad object (probably the victim and the witness), in doing so negating and projecting parts of their experience. Patient and analyst

come to believe that the projective identification cannot be released, because they equate the integration of the bad analytic object with something that cannot be survived.

In this particular case, the patient was breaking up with her boyfriend (the identified bad analytic object) at the time of the suicide. While the analyst may have believed that the break-up would mean the exit of the bad object (although I think unconsciously, the analyst knew better), the patient probably knew that there was no getting rid of the bad object, because the bad object resided within her psychological make-up.

Ogden understands human interaction as a process in which we are constantly seeking to negate aspects of our subjectivity in the hopes of experiencing something new and being transformed. Thus, the analyst is a willing container of the patient's projective identification because of the possibility of experiencing and creating something new and superceding the limits of what is otherwise one's limited self, "for the purpose of freeing themselves of who they had been up to that point." In this case, however, the analyst came into contact with an object that he did not want to be transformed by. One way to look at this case is from Maroda's perspective, where we could say that the analyst resisted identification with the bad analytic object because of the aspects of herself that she would have to confront to identify with the bad guy. Another possibility is that the analyst had never known and did not ever want to know an object so bad. Ogden suggests however that once experiences come to life in the analytic third, there is no going back for analyst or analysand, the material is either analyzed or lies in wait to be analyzed. Once the dyad gets involved, the analyst and patient can only delay.

In addition to Ellman's concept of analytic trust and Maroda's concept of surrender, Ogden's concept of the analytic third adds a way of understanding how the patient's past experience is created and comes alive in the analytic third. He also points out that once the analytic third comes to life, there is no turning back for either party. The experience of the analytic third must be analyzed or the analysis will be stalled.

Concluding Comments on Analytic Involvement:

There is much more to say about this clinical example which will reappear in the Results section. Ellman, Maroda and Ogden all believe that the analytic process is capable of handling any emotion at any intensity. Their clinical work speaks to a faith in the analytic process and a willingness to apply that process to any experience they have as an analyst, a willingness to enter a dyad without a knowing how they will be affected.

V. PSYCHOANALYTIC UNDERSTANDING OF SUICIDE:

While previous sections have set up a framework for analyzing the analytic involvement in cases of suicide. this section will provide a background for understanding the meaning of the suicidal act and the possible fantasies associated with suicide. Although the psychoanalytic literature on suicide is plentiful, it is based on theory and post-mortem observations of suicides in the general population. Theories of suicide have not emerged from case reports of patients who committed suicide in treatment. Thus. the psychoanalytic literature on suicide developed differently than the psychoanalytic literature on depression. psychosis. hysteria or other clinical phenomena. This distinction is due in part to the nature of suicide. It as an infrequent event and it is unlikely that a single therapist will have extensive experience with patients who eventually commit suicide. In addition. suicide is not a diagnosis. it is an act. Therefore. it seems to have fallen into a unique category of clinical and theoretical investigation. While all the major psychoanalytic theorists have commented on suicide, theorists and researchers who have focused on suicide are not in the psychoanalytic mainstream. They are specifically thought of as "suicidologists." In this section, I will briefly trace the development of psychoanalytic thinking on suicide from Freud on.

Freud (1901) mentioned the suicide of a patient in the Psychopathology of Everyday Life. In an effort to describe the symptom of forgetting under the influence of unconscious conflict, he describes forgetting a word unconsciously associated with the news of a patient's suicide. But this was not Freud's only experience with suicide. He

refers to several patients in his writings that had a family member commit suicide, the most famous of whom was the Wolf Man whose sister committed suicide.

In 1911, Freud comments on suicide: "We are, above all, anxious to know how it becomes possible for the extraordinarily powerful life instinct to be overcome; whether this can only come about with the help of a disappointed libido or whether the ego can renounce its self-preservation for its own egoistic motives" (Freud, in Litman, 1970). Freud tried to consolidate his thoughts on suicide within his evolving instinct theory. He made some clinical observations on suicidal ideation and self-destructive phenomena. He linked suicidal phenomena with 1. Unconscious guilt towards others, especially parental figures (Anna O.) 2. Identification with a suicidal parent (Dora) 3. Refusal to accept the loss of libidinal gratification (suicided patient referred to earlier) 4. An act of revenge (Rat Man) 5. A communication, a cry for help 6. Escape from humiliation 7. The fusion of self-destructive wishes and sexual pleasure in sadism and masochism (Litman, 1970).

He begins to address these questions in "Mourning and Melancholia" (Freud, 1917):

"We have long known that no neurotic harbors thoughts of suicide which are not murderous impulses against others re-directed upon himself, but we have never been able to explain what interplay of forces could carry such a purpose through to execution. Now the analysis of melancholia shows that the ego can kill itself only when, the object-cathexis having been withdrawn upon it, can treat itself as an object, when it is able to launch against itself the animosity relating to an object- that primordial reaction on the part of the ego to all objects in the outer world. Thus in the regression from narcissistic object-choice the object is indeed abolished, but in spite of all it proves to be stronger

than the ego's self. In the two contrasting situations of intense love and of suicide the ego is totally overwhelmed by the object, though in totally different ways." (Freud, 1917)

There are two major themes in Freud's view on suicide: 1. The hostility towards the object turned towards the self. 2. The factors which precede this level of hostility (the death instinct, masochism, the loss of a narcissistically loved object, abandonment by the loved object and the centrality of ambivalence in all love relationships).

Freud's thoughts on suicide are often quoted in a way that overemphasizes the first point of the hostility towards the object being turned towards the self as an oversimplified explanation for suicide (Litman, 1970, Perelberg, 1999). Freud noticed that melancholics tended to criticize themselves in a way that suggested that their complaints about themselves were in fact plaints against the object. Thus, self-recrimination was seen a means of expression of ambivalent feelings towards the object. It expresses hatred, "an attitude of revolt" and a desire to rectify the injustice felt. But, Freud pointed out that this was not simply about hostility. Melancholia was the result of an identification with the object, a wish to maintain a libidinal connection to the object and an enjoyment of the suffering produced by this connection. Thus, it was not all about hate, but also about love. The ego could split into the self-criticizing component and the narcissistically identified with the object component. In the case of suicide, the object overwhelms the impoverished ego. Freud likens this state of mind to the opposite state of being in love, the two situations where the object becomes more libidinally cathected than the ego.

Early on, Freud realized that a central question in suicide was to examine how the hostility could become so profound that it would obliterate self-preservative functions.

Some of this he explained away eventually biologically with the death instinct, a force imagined in constant battle with the life instinct. In other words, he conceived of the ambivalence towards the object as evidence of the destructive impulse turned outward into the world. Some of the vulnerability to suicide he explained sociologically. He saw human beings as subject to a long period of infantile helplessness where they are forced to comply with the demands of civilization, the parental world. Helpless inability to master the instincts and forced compliance resulted in the ubiquitous presence of masochism. So, biologically and sociologically, he saw all human beings as having a vulnerability to suicide.

But then what particular psychological circumstances could cause the ego to break down so profoundly? Loss of a love object or intense narcissistic injury could weaken the ego sufficiently, but only if the person were to have a predisposition to overly narcissistic libidinal attachments. Overwhelming affects of guilt and rage could weaken the ego, but only if the ego were prone to disintegration and extreme enough splitting where one part of the ego could kill off the other. Identifications could confuse the ego into equating death with life or reunion with a loved one, in the case of identification with a dead loved one or a suicidal loved one. Lastly, the ego could be overpowered by the superego, if the superego were identified with excessively cruel parental figures, particularly figures that wished the person dead.

Although Freud's ideas on suicide may be diverse and even contradictory at times, he lays the groundwork for the areas that will be further investigated by others. To summarize, he recognizes three central components of suicide. 1. Murderous impulses, not only towards self, but towards others. 2. The importance of ambivalent libidinal

attachments, love, and identification in suicide. 3. The circumstance of devastation following real or imagined loss, abandonment or narcissistic injury. Vulnerability to suicide is universal, but requires a predisposition to a weakened ego state. Lastly, Freud recognized the importance of a precursor that sets off the suicidal state of mind. All of these veins of thinking continue to be pursued by others.

As Klein developed her theoretical ideas about good and bad internal objects, she reframed Freud's ideas about the murder of the object in suicide. She describes the suicidal state as a state of "internal warfare" (Klein, 1937). When hatred increases, then attempts to preserve love within and without become more desperate. The bad internal object attacked in suicide is understood as a combination of the internalized harsh parent and the original projected destructiveness. The suicide kills off the hateful parent, the hated parent and the hate within the self all at once. A variety of theorists have subsequently shown that suicide is not only about hate, revenge and murder, but it is often dominated by a fantasy of reuniting with the idealized, gratifying good mother (Kubie, 1969, Litman, 1970, Bacal, 1981, Maltsberger and Buie, 1980).

Most theorists carried on an idea that suicide occurred when there was a confluence of motivations. Menninger (1933) contributed a triad of unconscious wishes that must be present for a suicide to take place: the wish to die, the wish to kill and the wish to be killed. These wishes are thought to derive from the id, ego and superego respectively. Suicide is seen as a symbolic act motivated by unconscious fantasy, thus, drawing attention to the choice of suicide method and the multiple meanings and messages in the suicide. Menninger's approach to suicide has a profound appreciation of the individual's ability to create the context of their own suicide. Thus, attention is drawn

away from the external insult, disappointment, loss or abandonment that precedes a suicide and the focus is maintained on the internal world of the person.

"We know that the individual always, in a measure, creates his own environment, and thus the suicidal person must help create the very thing from which, in suicide, he takes flight. If we are to explain the act dynamically therefore, we are compelled to seek an explanation for the wish to put one's self in a predicament from which one cannot, except by suicide, escape. In other words if, for one's own unconscious purposes, one brings about an apparent justification in external reality for self-destruction, the unconscious purposes are of more significance than the apparently simple, inevitable external realities." (Menninger, p.23, 1933)

Menninger never clarifies how the three universal wishes can create a suicide. The suicidal individual is supposedly different from others in the way in which he creates an environment where suicide is seen as the only escape from internal and external conflict.

Menninger looked at the similarities in suicide. Zilboorg (1936), on the other hand, looked at the differences amongst suicides in the most comprehensive early psychoanalytic research on suicide. He found suicide took place across diagnostic groups. He suggests that Freud's idea that hate was turned towards the self has misled clinicians to believe that suicide does not occur in outwardly hostile people. Cases are presented of openly hostile patients where agitation, panic and spiteful behavior are actually forerunners of suicidal crises. This observation is later confirmed when Hendin's (1987) research found that 50% of young suicides have a history of aggressive and antisocial behavior while less than a quarter show evidence of major depression.

Studies of suicide across several diagnostic groups led to interest in the suicidal state of mind rather than the underlying dynamics of suicide in the hopes of improving assessment and prevention of suicide. Beck (1975) found the high levels of hopelessness predicted suicide more than high levels of depression. In addition, Fawcett etal. (1990) found that high anxiety predicted short-term suicide risk more accurately than high rates of depression or hopelessness, which predicted long-term risk. This has led to an interest in suicide in the case of panic disorders. The leading researcher in the area of the suicidal mind, Edwin Shneidman, (1993) clarifies that suicide is not a mental disorder, it is "a transient tempest in the mind" born out various mental disorders. He suggests that the suicidal individual subjectively experiences intolerable psychic pain (he calls this *psychache*) which can due to excessive shame, guilt, humiliation, loneliness, fear, angst or dread of dying. Suicidal persons feel blocked or frustrated from certain psychological needs that are experienced as vital to continued life. The primary goal of the suicide is to reduce pain. The person believes that cessation of consciousness (death) is the only solution. The suicidal mind is characterized by cognitive constriction, a state where the person cannot imagine any other solution to their unbearable pain. In this framework, Shneidman suggests that the suicide risk can be judged by the patient's level of lethality and perturbation. While lethality marks their physical capacity to kill themselves, Shneidman insists that the level of perturbation is much more critical. Perturbation is the person's subjective experience of whether they can tolerate their painful state of mind (Shneidman, 1980, 1993).

Shneidman's model focuses on what the suicidal mind seeks to escape: subjectively intolerable psychic experience. But, another vein of psychoanalytic writing

emphasized the importance of what the suicidal mind may be running towards: reunion with a love object, rebirth or nirvana. The earliest interest in this came from Jones (1911) who examined the impulse to die together with a loved one. He believed that this impulse belied a belief in "a world beyond, a region where all hopes that are denied in this life will come true." (p.11, Jones, 1910). Suicide could serve the function of wish-fulfillment. He suggested that the wish would be strongest when life was most disappointing. In essence this is basically a different theoretical understanding of Klein's (1937) later observation that the urge to reunite with the gratifying mother is strongest when hate of the bad mother is most profoundly felt. Jones felt that the fantasy of entering paradise through death was a complicated fantasy, both a wish to return to the womb and a libidinal wish to sleep and lie with the mother for eternity.

Friedlander (1940) pursued an interest in the "wish to die", feeling that psychoanalysts overemphasized hostile wishes in suicide: the wish to kill and the wish to be killed. She examines suicidal fantasies that are driven by libidinal desires. Fantasies such as incorporating the object, lying with the love object in sleep and being saved by the loved one all manifest strong libidinal wishes where aggression may be secondary. When destructive fantasies are understood, but libidinal fantasies remain unanalyzed, the patient may remain at risk of suicidal enactment, unconscious of the tendency to seek gratification and unable to recognize the unrealistic suicidal fantasy. She suspects that libidinal fantasies are predominant in suicidal gestures of children whose reality testing about death allows them to believe that gratification may come in the form of death.

The wishes of suicidal patients are complicated and yet they are not uncommon wishes: murderous wishes, self-destructive wishes, libidinal wishes, incestuous wishes,

identificatory wishes are standard psychoanalytic fare. The presumption is that in cases of suicide, murderous and self-destructive wishes have reached a high, libidinal gratification has plummeted and hope of escape of psychic torment in life has ceased. Theorists have suggested the suicidal person is unable to call on good, soothing internal objects in the suicidal moment (Adler and Buie, 1979).

Jensen and Petty (1958) suggest that the difference between the successful suicide and the suicide attempt is not in the wish to kill, to be killed and to die, but in the wish to be saved. In every successful suicide lies an unfulfilled wish to be saved. After analyzing 600 cases of suicide, the researchers found that they were always able uncover communications of the suicidal intent. Thus, they suggest that every suicide is committed with some degree of ambivalence. Two other findings are of interest. They found that the more disturbed the person, the more likely the communication was incoherent and the rescuer chosen a more distant representative of a parental figure. Less disturbed suicidal people made more coherent communications to more intimate friends and family. However, this did not mean that the clearer the communication, the more likely that the suicidal person was rescued. The second finding was that the emotional availability of the chosen rescuer was critical to the rescue fantasy being enacted. The rescuer must have "a surplus of libidinal energy with which to love the suicidal one and initiate the rescue and he must have sufficient ego strength to deal with the destructive impulses not only of the one he is to rescue but his own as well whether they are directed toward himself or the suicidal person." (p.137 Jensen and Petty, 1958). Thus, they cited several cases where the suicidal person gave a coherent message to someone close that was denied or

misunderstood because of the potential rescuer's unconscious ambivalence towards the suicidal person.

The researchers recognized the importance of their findings to the therapy of suicidal patients, where the therapist must pay attention to the patient's attempts to cast them as rescuer or abandoner. They suggest that the therapist, in order to enact or interpret the wish to be rescued, must have the ego strength to deal with the patient's destructive wishes and the therapist's own hostile feelings towards the patient. Jensen and Petty believed the wish to be rescued rose out of a repetition of an early trauma of abandonment by the primary object. The wish is an attempt to repair and restore the early relationship.

Asch (1980) looked at how the reverse of the wish to be rescued was the wish to cast someone else as the executioner. He believed that all suicides evidence some degree of ambivalence, whether a particular person is slated as executioner/savior or Fate (as a screen for the parent) is the deciding factor. Each suicide achieves the double aim of cleansing the self and reuniting with the omnipotent love object (Asch, 1980). Studies of dreams of suicidal patient and the devices of the suicidal act have been used to confirm the complex fantasies enacted in suicide (Gutheil, 1948, Maltsberger and Buie, 1980).

The Relationship of Violence and Suicide

A recent volume of papers by contemporary psychoanalysts looks at the relationship between the violent and suicidal enactments of patients (Perelberg, 1999). Like psychoanalytic investigators before them, they focus on the faultiness of the separation/ individuation as the root of self-destructive and violent enactment. But the

contemporary authors are also interested in ideas about the reflective process (Fonagy and Target, 1999) and the role of the father as facilitator of the separation from the mother and the representative of secondary process, thinking and reflecting.

Overemphasis on aggressive wishes in suicide is criticized and it is argued that Freud was equally interested in love and identificatory processes in suicide. Glasser's (1985) model of distinguishing between self-preservative violence and sadism is used to reevaluate the motivations for destruction. This model suggests that self-preservative violent enactments occur out of the individual's belief that they will engulfed by the other or left for dead by the other. In self-preservative cases of suicide, the aggression is meant tc "free the self through the destruction of the other within the self" (Fonagy and Target, 1999). Sometimes, self-expression or separate psychic existence have become fused with acts of aggression because of disturbed separation processes. The suicidal act is an attempt to separate from an engulfing mother (Fonagy and Target, 1999).

Sadism is also redefined. Sadism is seen as a higher level form of violence because the enjoyment of the other's suffering implies that there is some empathy with the mind, thoughts and feelings of the other. Sadism is also seen as a way of amplifying stereotypic interaction so that the person can experience psychic contact with the other.

Fonagy's notion of *mentalisation* is used to understand the inability of suicidal and violent patients to contain their enactments in treatment (Perelberg, 1999, Fonagy and Target, 1999, Bateman, 1999, Davies, 1999). Mentalisation is understood as a developmental achievement. In normal development, the child comes to imagine the thoughts, feelings and intentions of the primary object toward the self. In addition, the child becomes able to imagine a third perspective on the relationship (symbolically the

father's perspective on the mother-child relationship). The development of mentalisation fails when the child experiences the thoughts and feelings of the primary other towards the self are intolerable, or literally un-thinkable. When the caregiver's thoughts about the child are too malevolent, the child does not develop the mentalisation capacity as a way of refusing to contemplate intolerable psychic experiences. Other theorists have supposed that the child may not be able to accommodate the third or the reflective process because the child cannot tolerate thoughts of parental intercourse or holds an unconscious belief that all intimate relationships are violent based on primal scene fantasies (Britton, 1989, Perelberg, 1999). Fonagy and Target (1999) suspect that intolerable thoughts are not limited to the primal scene. For example, they agree that the boy's wish to kill the father in the oedipal situation derives from a sense of rivalry with the father. But, in cases of disturbed mother-son dyads, the son also wants to kill the father as the witness of his humiliation and rejection at the hands of the mother. In all the clinical cases, the father's absence is considered crucial to the faulty separation/ individuation process. They are referring to a physically absent father, a rejecting father or a father denied by the child because of the father's association with terrifying primal scene thoughts.

A further step is required to understand how a failed reflective process can result in suicide. A physical attack on one's body results from a situation where destroying or attacking the body becomes equated with destroying intolerable psychic experience. The body comes to be seen as separate and alien from the self, all of the unwanted parts of the self are projected onto the body, which must then be eliminated (Segal, 1986). Control over intolerable mental experiences is achieved by the fantasy that those mental objects are incorporated into the body (Fonagy and Target, 1999).

A last concept that is shared amongst this group of contemporary theorists is that a notion of a "surviving self" belies all fantasies of suicide (Campbell, 1995). This concept is a derivative of Friedlander's (1940) understanding of the wish to die. The authors suppose that while the patient kills off the engulfing and abandoning mother with the body, he believes that the self survives this attack and can live in perpetuity merged with the idealized mother. The concept of the surviving self is used to explain the clinical experience of many therapists that patients are calm, withdrawn and blissful in the time immediately preceding the suicide.

Summary:

Complex meanings, fantasies and mechanisms of suicide have been explored in the psychoanalytic literature. The wish to kill, the wish to be killed, the wish to die and the wish to be rescued have each been examined. A suicide can achieve wish fulfillment through self-punishment, the punishment of the other and an imagined transition into a blissful state. Contemporary theories have elucidated how common fantasies can reach a pitch that they are enacted on the body. Faulty thinking processes, the failure of separation individuation and the role of the body as the stage for action are seen as the necessary components for a person to turn suicidal fantasy into action.

VI. THE IMPACT OF SUICIDE ON THE THERAPIST:

The therapists interviewed in this study will have experienced a patient's suicide. To gain a deeper understanding of the therapist's experience, we must understand the personal and professional impact of a patient's suicide. A significant literature has been written on the impact of suicide on family members, but only a few articles have been written on the impact of suicide on psychotherapists. Though few, these articles suggest that the impact of suicide can be very significant on the therapist's personal and professional self.

Edwin Schneidman pointed out that "Suicide is a personal and an interpersonal disaster. The moment of the disaster's happening is its most dramatic moment. But it is not its only moment." (Schneidman, 1993) While the act of suicide may be the defining moment, the antecedents and the grief that follow a suicide could all be considered a part of the larger disaster. In this section, I provide a brief overview of the research on the impact of suicide on family members. Then, I will focus on the issues of psychotherapists as suicide survivors.

Impact of Suicide on Survivors:

Most of the research into the impact of the suicide on survivors has been conducted on bereaved family members. The research followed the clinical presentation of symptomatic surviving family members. Based on clinical experience, Norman Farberow suggested that mourners of a suicide are different from other mourners in several ways (1993).

While many mourners question why their loved one died, suicide survivors are particularly focused on the question "why?" Farberow (1993) suggests that this quest for understanding is an important part of the mourning process in cases of suicide. It can lead to closure where the bereaved feels closer to understanding the departed. The mourner may be reassured by making some sense or logic out of the deceased's decision to suicide. On the other hand, the search for meaning can become obsessive when it serves as a refusal to let go of the loved one. The search for meaning can facilitate or obstruct the mourning process.

In a follow-up study of widows of suicided policemen in the 1930's, researchers found that each of the widows had an explanation for the suicide. Few in the sample overtly said they didn't know the reason for the suicide (Kamerman, 1993). In a study of survivors of more recent suicides, it was found that survivors all had agonizing questions about the suicide. Those who had reached some understanding of the suicide or had accepted that they would never know the answers to certain questions, recovered more from the trauma (Van Dongen, 1990).

Suicide survivors are also likely to feel more guilt than the bereaved of those who died of other causes (Farberow, 1993). Farberow suggests that the expression of guilt can lead to an appropriate assessment of one's responsibility and an acceptance of the limits of one's responsibility for another's life. But guilt can also manifest in endless "if only" self-doubts. Guilt can appear as intense self-blame and self-recrimination or intense projection of guilty feelings by blaming others. Heightened levels of guilt and sense of responsibility were found in empirical studies of suicide survivors (Hauser, 1987; Bailey, Dunham, Kral, 1999)

Survivors of suicide can suffer additional emotional distress because of the social stigma associated with suicide. This stigma may lead to isolation from normal social support during a time of mourning (Hauser, 1987). Farberow suggests that society brands both the deceased and the suicide survivors as psychologically damaged. Survivors of suicide were found to be ashamed of the suicide in their family. They were also found to perceive stigmatization from their social environment (Bailey, Dunham and Kral, 1999). One study found that the only mediating variable between suicide survivors who had extensive problems after the suicide and those who did not, was the level of social support in the aftermath of the suicide. The grieving process was strongly influenced by the reactions and attitudes of others to the suicide (Rudestam, 1992).

Clinically, several other problems have been noted with suicide survivors that have yet to be researched. It has been suggested that a suicide in a family serves as a model. In other words, suicide as an act comes to be seen as an option for unresolvable problems. Some have found that in the aftermath of a suicide, suicidal ideation has a contagious quality (Hauser, 1987). This can be seen as an identification with the suicided loved one. Anecdotally, it has been reported that survivors of suicide are more likely to have accidents, which may also be viewed as unconscious identification with the deceased (Farberow, 1993).

Therapists who work with survivors of suicide more in depth have found profound feelings of abandonment and rejection. Survivors can manifest this in difficulties with trust in intimate relationships or an inability to commit to any intimate relationship at all. Farberow (1993) also pointed to the difficulty survivors often have expressing anger at the dead in general, but particularly in cases of suicide where they

may be feeling guilty about their relationship with the deceased. Unexpressed anger can cause emotional strain as it may be defended against in pathological ways.

In summary, the bereaved were found to have many additional obstacles to the normal mourning process in cases of suicide. Difficulties were found in several areas. Survivors searched for meaning on an obsessive way to avoid feelings of loss. Guilty feelings manifesting in excessive self-recrimination or excessive blaming of others were found to inhibit the mourning process. Many survivors experienced social isolation due to the stigma of suicide in the social environment. Unconscious identifications with the dead, accident-proneness and the contagious quality of suicidal ideation have all been experienced clinically in suicide survivors. Inhibited anger and profound difficulties trusting other and achieving intimate relationships were also found.

Impact of Suicide on Therapists as Survivors:

An estimated 51% of psychiatrists and 22% of other mental health professionals will have a patient commit suicide at some point in their professional practice (Chemtob etal., 1988). In addition, it has been found that 37% of psychiatry residents experience a patient suicide during training and 14% of psychology and social work students experience a patient suicide during their clinical training (Brown, 1984). However, remarkably few therapists have written about their experience of a patient's suicide (Kolodny etal., 1979; Gorkin, 1985; Foster, 1987; Campbell, 1995). It has been suggested that this is a result of fear of professional embarassment and fear of malpractice lawsuits from the deceased patient's family. Even Freud and Winnicott who mention the experience of a patient's suicide in their writings, never wrote up those cases.

A few key studies have looked at the short and long term impact of a patient's suicide on a therapist. Each study has found that the suicide of a patient has significant impact on the therapist. However, each of these studies has only alluded to some of the severe disturbance they found in therapists subsequent to the suicide.

In a study called *The Patient's Impact on the Analyst*, only one chapter out of eleven is devoted to the "potential negative impact" of patients on their analysts (Kantrowitz, 1996). The author explains that her neglect of the negative impact accurately represents how little analysts spoke about negative experiences with patients even in an anonymous research project. She recommended a future study that specifically elicits negative experiences. Most responses about negative impact were offered by analysts as anecdotes about other analysts (Kantrowitz, 1996). Anecdotes about analysts leaving the field after a patient's suicide were reported.

In the first study specifically about the impact of suicide, 200 psychotherapists were interviewed "shortly after the suicide" (Litman, 1965). These findings only reflect the short-term impact of the suicide. Therapists who were known to have had a patient commit suicide were approached by interviewers, thus, the population was likely more inclusive than the voluntary studies which followed this seminal study. Many of the therapists did not initially wish to participate. Litman (1965) found that therapists often took the suicide as a personal defeat. They felt guilty and experienced self-doubt. . Therapists were found to feel especially guilty, responsible and inadequate if the deceased was a prominent person or someone of a high social value such as a respected professional or a young mother. Simultaneously, some felt anger at the patient's spouse

or their supervisor on the case. Expressions of overt hostility towards the deceased patient were rare.

On a more personal level, several therapists were found to have felt partial identifications with the deceased, even so far as experiencing accident-proneness in the weeks after the suicide. These findings suggest that the therapist as suicide survivor experiences many of the same difficulties as bereaved family members: guilt, excessive blaming of others, identifications with the dead and inhibited hostility towards the suicided patient. Some therapists discussed feeling additional sadness if they felt the associated an older patient to a dead parent.

Litman (1965) found several factors that mediated the impact of the suicide. Suicides that took place in an institutional setting were tolerated better than suicides in private practice, especially if the institutional setting was supportive. Therapists who sought consultation or supervision prior to the suicide felt more resolved about their adequate efforts to help the patient.

Professional changes after a suicide were investigated further by a variety of studies. Therapists were found to have become more conservative in their approach, particularly regarding termination, more attentive to signs of suicidal ideation and more likely to explore any signs of suicidal ideation. They were more likely to actively introduce questions about suicidal ideation and more likely to hospitalize a patient, seek consultation, and keep extensive notes (Menninger, 1991). The number of therapists who refused to work with suicidal patients after the suicide varied depending on the study, but many were found to have changed their technique with suicidal patients. Many therapists denied that the suicide had an impact on them, but simultaneously pointed out changes in

their clinical work and attitude towards patients. Most therapists were found to have intense feelings about the suicide even many years later (Goldstein and Buongiorno, 1984).

Several researchers noted that therapists went through a significant evaluation of their omnipotent fantasies towards patients (Litman, 1965, Goldstein and Buongiorno, 1984, Menninger, 1991, Brown, 1987). Therapists first-person accounts of patient suicide mentioned the struggle to come to terms with rescue fantasies and fantasies of omnipotent control over patients' lives. Many referred to the experience as a "rite of passage," where the therapist struggles with a central paradox of working with patients. Some patients will inevitably suicide, but therapists must also accept the possibility of their own failures and the failures of the psychotherapeutic method. In a series of recommendations, Litman (1965) said that an attitude of "nothing could be done" leads to a nihilistic attitude where as a belief that suicide is always preventable leads to excessive self-blame. He recommends a middle ground approach to suicide where therapists can review the case and attempt to learn from a suicide to become more sensitive and improve their professional judgment.

Brown (1984) addressed the specific impact suicide may have on therapists in training. He saw inexperienced therapists as particularly vulnerable to being affected by a patient's suicide. He interviewed psychiatrists and found that 62% of those who had a suicide during their residency said the event had a profound impact on them. This group stated that the impact was "for the better." Brown sees inexperienced therapists as likely to be deeply invested in being helpful and unaware of their narcissistic aspirations regarding patients. Early in training, they might be less accustomed to uncomfortable

countertransference feelings regarding difficult patients and therefore less likely to share those feelings during supervision or even after the suicide. They might even deny the feelings altogether in a way that would make processing the suicide of the patient difficult. Brown saw suicide as potentially deeply traumatic for trainees because they may have little differentiation between their professional sense of self and their person. Thus, the suicide is taken as a rejection of their person. He found a tendency of trainees to regard themselves as bad therapists or their patients as bad patients.

To summarize the researchers findings, it might be helpful, to put a developmental frame around the experience of the suicide. Indirectly, the researchers were also looking to see if the suicide had a negative impact on the development of the therapist. Although some found evidence of therapists openly developing a nihilistic attitude toward therapy, more often responses to the suicide were subtle. Some therapists shifted away from suicidal patients without ever really addressing the painful feelings of the suicide. Other therapists redoubled efforts to take on more responsibility towards patients and sought to make sure that a suicide would never happen again.

All reports indicate that therapists continued to have intense feelings about the suicide long after the event. Goldstein and Buongiorno (1984) noted that therapists are faced with issues about therapeutic failure, their influence over patients and their lack of omnipotent control repeatedly in work with any patient population. Therefore, the same feelings elicited by the suicide must be faced in clinical practice on a regular basis. The researchers normalized the intense feelings of anger, guilt, and shame that characterize the process a therapist goes through after a suicide. They also acknowledge that this process is often interrupted prematurely. However, researchers never really probed for

negative developmental outcomes. They also never judged whether the therapists were subsequently impaired in their work.

Robert Litman (1994), in a summary of his research, mentions that he considered writing a paper about whether psychoanalysis increases suicide risk. He refers to unpublished reports that 7 to 15 of the earliest psychoanalysts committed suicide. He also refers to several cases where psychoanalysts were personally or professionally devastated after the suicide of a patient, including Ralph Greenson after the suicide of his famous patient, Marilyn Monroe. But these stories are relegated to psychoanalytic myth and lore and the research takes a much more superficial approach to the problem.

While researchers were not expansive about the negative impact on some therapists, several outlined what they thought would most likely lead to a healthy processing of the event of suicide (Litman, 1965, Goldstein and Buongiorno, 1984, Brown). Litman (1965) suggested that ideally the therapist should eventually be able to use the experience to be more sensitive and exercise better professional judgment. He recommended that therapists recognize the limitations of therapy without losing hope. Goldstein and Buongiorno (1984) suggested that the therapist needs to incorporate the experience into his personal and professional life.

All agreed that sharing the experience with others was extremely important. Litman (1965) found that 90% of therapists shared their experience with colleagues. There was also general agreement that the response of colleagues and supervisors was important to the working through process. In the immediate aftermath of the suicide, it was recommended that support focus on the therapist's feelings of grief. Only later was it found useful to examine the case in depth to search for clinical understanding. Therapists

seemed unanimous across several studies that it was most helpful to them if they could talk about the case in depth in a supportive environment where the goal was learning from the experience (Litman, 1965, Brown, 1984). Consultation, supervision or case conferencing was thought to go astray when supervisors or peers attempted to whitewash the event (Sacks etal., 1987). Substantive discussion was necessary for the therapist to feel they had adequately assessed their responsibility in the suicide. On the other hand, scapegoating of the therapist, any member of the treatment team or any member of the patient's family was not considered useful.

In summary, the experience of a patient's suicide was found to have a significant impact on therapists. Feelings of grief, loss, and fears of professional incompetence were common among therapists. Therapists were found to have made significant changes in their clinical technique particularly around suicidal patients. Some therapists refused to do further work with potentially suicidal patients. The response of the therapist's professional community was important to the therapist's process of working through the trauma of a patient suicide. These preliminary studies did not address whether therapists were subsequently impaired in any significant way in their clinical work.

VII. Conclusion of the Literature Review and Statement of the Research Problem:

I have reviewed four major areas of literature for this study: action in psychoanalysis, contemporary perspectives on the analytic involvement, the psychoanalytic understanding of suicide and the impact of suicide on psychotherapists.

I reviewed the concept of action in psychoanalysis, which included a review of countertransference and enactment. This sets up a theoretical framework where the suicidal act can be examined for its meaning in the analytic relationship. I then reviewed three perspectives on the analytic involvement to begin to set up a framework from where disturbances of analytic involvement in cases of suicide could be examined more deeply.

I reviewed the psychoanalytic understanding of the phenomenon of suicide to present a background of theoretical understanding of the central dynamics, fantasies and object relations in cases of suicide.

Finally, I presented the limited data on the impact of the suicide of a patient on the psychotherapist. This study relies entirely on the recollections of the therapist. It is important to understand how the experience of the patient's suicide may have affected the therapist.

Although a lot has been written about suicide, less has been written about suicide in psychotherapy. Limited research has investigated the impact of suicide on the psychotherapist and the question, "what goes wrong in cases of suicide in psychotherapy?" A systematic, intensive study of cases of suicide from the perspective of the therapist has not been done.

What can the experiences of therapists who have had a patient commit suicide in treatment teach us? There are several levels at which something could be learned from

examining therapist's experiences of patient suicide. 1. As clinical wisdom is mostly gained through experience, we can find out what therapists learned from involvement with the patient, from processing the patient's death and from their continued application of this learning to work with subsequent patients. 2. We can look at the themes and issues that are repeated across multiple cases, attempting to gain knowledge and generalizability that can't be gained from investigating a single case. 3. We can apply certain concepts such as countertransference, enactment and analytic involvement to see if we learn where the analytic process fails.

An intensive, case study model from the therapist's perspective offers a unique opportunity to look closely at cases of suicide in psychotherapy and understand more deeply the challenges of being involved with patients in a therapeutic way.

CHAPTER 3

METHODOLOGY

Why a qualitative study?

This study explores therapists' experiences of patient suicide. While several studies have investigated the "impact of suicide" on the psychotherapist, none of these studies have asked the therapist in depth about their experience with the patient. None of the studies have asked the therapist to review the case in depth and reflect on what they learned from the overall experience of the patient. In this study, therapists were asked to reflect on their involvement with the patient, their reactions to the suicide and the way in which the experience of the suicide has been integrated into their overall clinical experience and knowledge. They were asked to explain how they have come to understand the meaning of the suicide in their relationship with the patient and in the context of the patient's life. They were asked if this understanding has evolved since the suicide. They were asked if they learned anything from the experience and how this learning has been integrated into subsequent clinical practice.

Exploration of this area of clinical practice is best supported by a qualitative research methodology. Qualitative research allows this study to be inductive where concepts can emerge from patterns in the data. As cases of patient suicide may vary greatly, a qualitative study allows for a case-focused and an issue-focused approach. A case-focused approach will capture the individual experience in a deep and meaningful way, while an issue-focused analysis will allow us to learn from all participants about a specific issue or theme.

Qualitative research also includes attention to the effect of the researcher on the subject. In the case of traumatic experience like patient suicide, understanding the effect of the interview on the subject is critical.

The aim of this study is to get the deepest possible understanding of therapists' experiences of patient suicide. A qualitative methodology allows the researcher to empathize and identify with the people they study in order to gain a fuller understanding of the subject's perspective (Taylor and Bogdan, 1984).

Why a case study design?

This investigation utilized a case study design. Case studies have played a central role in clinical psychology and psychoanalysis and have been used to develop and evaluate therapy techniques and call attention to uninvestigated clinical phenomena (Kazdin, 1992). A case study method allowed me as interviewer to enter the therapist-subject's psychological space and in this way to come as close as possible to understanding how the therapist felt being involved with this patient. The therapist-participant was asked to talk about their experience of the patient and the patient's suicide. In an open-ended, clinical format, the subject was not asked to guide their responses around my interview. This method allowed the interviewer to probe further in certain areas without overdirecting the interview. Of course, this investigation had a focus and participants were told that I was interested in learning how they experienced their involvement with the patient, how they had experienced the patient's suicide and what, if anything they felt they learned from the experience.

The Pilot Study:

A pilot study was initiated to test the original interview protocol. The initial protocol was much more structured than the open-ended interview protocol that was used. Two subjects were interviewed two times each with two weeks in between.

In addition to questions derived from the literature review, the interview included many questions about the patient. I anticipated that I would be able to get a diagnostic picture of the patient through the therapist's description. At the end of two interviews, I found that I knew little about the patients. I had gathered enormous data on how the therapist felt being with the patient and thus I felt I had some sense of the relationship between therapist and patient, but little sense of the patient as an individual.

I also discovered in my first pilot interview the importance of the interview being a revisiting of a significant trauma. I found that my linear list of questions was detracting from the rapport with the interviewee. Much more data was elicited from the subject when I allowed the subject to tell the narrative of his experience in his own way. Psychobiographical research has suggested the importance of flexible interviewing strategies to elicit a more substantive picture of the individual subject (Newton, 1995).

This study is in a sense biographical, although narrowly focused on one life event and the impact of that event on the therapist's career. Research on interviewing survivors of trauma also suggests that it is therapeutic to allow the person to retell the story in their own words, asking questions only to facilitate a further elaboration of the narrative. While I was not seeking to be a therapeutic presence in the interviews, it seemed important that my interview not be experienced as anti-therapeutic. I was open to the

possibility that my "investigative" questioning could be experienced as intrusive or persecutory, which could lead to the interview being retraumatic for the subject. I wanted the therapist to feel free to discuss a range of difficult experiences of a traumatic event in a substantive way. I sought to find a thoughtful, sensitive and empathic stance that would facilitate the therapist's revealing intimate feelings about a traumatic event. At times, I anticipated, I would get defensive responses from the therapists. However, the interview was meant to be neutral so as not to induce additional defensiveness.

By the time of the second pilot interview, I settled on a new format that resembled in some ways a clinical interview. I asked the second pilot subject to tell me about his experience of the patient's suicide starting wherever he wanted and I indicated that I would intervene when I felt I needed more information or clarification. I kept a list of questions at hand that I referred to at the end of the first interview. In the second interview, I further explored certain themes from the first interview and made sure to cover any questions on my list that had not already been answered.

My experience during the second pilot interview confirmed my prior experience in that I felt I learned little about the particular patient. I learned a lot about how the therapist felt towards this particular patient. I do not mean to minimize my findings. In fact, I was surprised at how the pilot study was able to get at the incredibly powerful and intimate feelings the therapists had toward their patients.

Research Materials:

The interview protocol that was developed from the pilot study will be used (SEE APPENDIX A). In the pilot study, it became clear that a highly structured interview was not most effective at engaging the subjects' collaboration in the interview and producing data that spoke to the depth of therapist's experiences of patient suicide. Structured, linear questions seemed to inhibit the subject's natural flow of expression. I found it more effective to allow the subject to talk spontaneously about their experience of the patient. Before this spontaneous narrative from the therapist, I elicited some basic biographical data about the therapist and his training and I asked the therapist to orient me to the context of their work with the patient. This phase was meant to create an initial rapport and to establish the therapist's authority in the situation.

In the next phase of the interview the therapist was prompted with, "Tell me about your work with this patient." During this phase, I only interrupted to ask clarifying questions. At times I asked the therapist to talk more about a certain point. For example, ifthe therapist repeatedly referred to the suicide note without discussing the content of the note, I would say, "what did the note say?"

During the interviews, I checked my list of questions to make sure I have heard about each area. Even if the therapist answers certain questions in their spontaneous narrative, I asked them again, specifically questions like, "Prior to the suicide, were you optimistic about the treatment? Can you trace your optimism/ pessimism through the phases of treatment?" or "If you could do it again, would you do anything differently?" These questions force the therapist to reflect on certain issues.

Subject Selection and Criteria

Subjects were psychotherapists who had a patient suicide in their clinical practice. Subjects were recruited via word of mouth, through colleagues. Subjects were recruited via e-mail lists of psychoanalytic institutes and organizations. A notice was also be circulated to the members' mailing lists of several psychoanalytic institutes. This notice explained the purpose, protocol and confidentiality of the study.

Psychotherapists who had a patient commit suicide in their clinical practice were instructed to contact me directly, if they were interested in participating in the study. I then responded to the potential subject by phone or e-mail to give the subject further opportunity to ask questions about the study before agreeing to participate.

Subjects who were involved in a malpractice lawsuit related to the suicide were excluded from the study. Subjects who were within the time period (three years from the suicide) of the statute of limitations for a lawsuit were also be excluded from the study. These exclusions were instituted to protect the confidentiality of the subject insofar as possible and to avoid the possibility that research data could be subpoenaed by legal authorities in the case of a malpractice lawsuit.

Procedures:

Interviews took place at the private office of the subject. Each subject was asked to sign an informed consent form (see Appendix B). This consent explains the purpose, protocol and confidentiality of the research. Subjects were given the option to review any

written material pertaining directly to them to approve of how their confidentiality was protected.

All interviews were audiotaped. The audiotapes were transcribed by me. Two copies of each interview transcript were made, one for the file and one to be available for writing on during data analysis.

Data Interpretation:

The narrative data was analyzed in two main ways. A working list of themes was developed directly from the data. This allowed for themes to emerge both within a singular case and across cases. It also allowed themes to emerge spontaneously from the data that were not necessarily anticipated by the study or the review of relevant literature.

In another step, relevant theory from the literature review was applied to the data to gain a deeper and fuller understanding of the theory and the experience of the therapists. In particular, I was looking to see how the analytic involvement proceeded in each case with attention to the particular challenges met by each dyad.

I attended to the points of derailment in the analytic process, whether these derailments are spontaneously identified by the therapist or during my data analysis. Theoretical understandings of analytic involvement, enactment, countertransference and projective identification were applied to the case material. Therapists' experiences were compared to one another to derive common themes.

CHAPTER 4

PROCEDURES:

Descriptive Data about Therapists, Patients and the Process

In the first section, I will summarize the process and provide descriptive data about the therapists interviewed and their patients.

Participant Recruitment

Therapists were recruited through two methods, word of mouth and mass mailings/e-mailings. Colleagues, dissertation committee members and supervisors contacted therapists of their acquaintance who had experienced a patient's suicide in the practice. 3 subjects were recruited through this method. Mass mailings/e-mailings were sent to 3 psychoanalytic institutes in New York City and one national psychoanalytic organization. 10 subjects were recruited via this method.

Why did the therapists agree to participate?

Several reasons for participating were identified by participants. Therapists mentioned that they felt the interviews were a therapeutic opportunity to revisit the traumatic experience. Some stated this agenda from the outset and others noted the therapeutic benefit only at the end of the interview process. Contributing to research was also seen as a reparative gesture, either by giving to the field as a whole or giving to me as a graduate student struggling to complete a dissertation. Desire for a greater intellectual understanding of the case was often mentioned. Several therapists commented

that they felt participating in the study was a demonstration of respect for the patient's memory

. Many participants agreed to participate because of positive feelings towards the colleague who contacted them or the colleague who wrote the mass emailings/ mailings.

There were signs that participants had more unconscious or unspoken reasons for participating. At times, the therapists seemed to need to unburden themselves of painful doubts and secret fears that haunted them in a neutral atmosphere. Sometimes, I suspected that the therapists wanted a kind of vindication from me or wanted a confirmation of defensive attitudes towards the suicide. Many therapists seemed to be looking for a collegial, informal consultation. Talking to a graduate student may have felt less threatening than a formal consultation Most therapists mentioned ambivalent feelings about participating in the study. Most of the therapists were deeply concerned about their confidentiality and the confidentiality of the patient. Some were anxious about being judged by the members of my dissertation committee. They worried about reexperiencing painful feelings unnecessarily. I suspect that the therapists who participated felt they had something significant to gain in the process.

How did the therapists experience the interviews?

While all of the therapists found the interviews painful and at times unpleasant, they also seemed to find them therapeutic. Frequently, they commented on how they enjoyed recapturing a fuller memory of the patient that included more than just the memory of the traumatic suicide. The interviews seemed to revive memories of the patient and the treatment. Therapists often found themselves laughing and smiling

remembering pleasant experiences with the patient. Thus therapeutic moments of mourning took place. The therapists seemed to appreciate being able to recapture more nuanced feelings towards the patient.

One therapist explained:

I think that is what I have liked about this in a way because, that's a shame to just think about her as my patient who killed herself or the way she killed herself and she has come more alive. Her living part has come more alive than I ever really think of her. In terms of what object she has become. She has become the suicide object and uh, which I think is important and useful but she was more than that. I think that is what is hard and I think that is what... the way the relationship is punctuated. Like the way people don't like viewing the body at the funeral because they don't want that to be the image that stays with them.

All of the therapists commented by the end of the interviews that they had gone much further into the experience than they had expected to from the outset.

How did I experience the interviews?

The interviews allowed me the opportunity to explore with a group of therapists a very private realm of their professional experience. I heard areas of clinical practice that are usually invisible in case presentations, from the minute details of how therapists conduct their practice to the complex feelings therapists have for patients. I found that therapists were interested in using the interviews as an opportunity for their own growth. The most difficult part of the interviews was dealing with the intense anxiety and conflict I felt about the intrusiveness of the study. When I developed in my own ideas that may have challenged the therapists' understanding of the case, I struggled constantly with worries of how the therapists would feel about my idea, especially if I wrote about them

in the dissertation. I worried that they had given me so much and that I wanted to respect that and show my gratitude in my description of their work.

As an interviewer, I was juggling several roles. I was a researcher/ interviewer but felt anxious about being too intrusive. While there was a therapeutic element at play, none of the therapists had given me permission to be a therapist, so I was cautious of the boundaries of the interview. While there was an element of a collegial consultation, none of the therapists had given me permission to consult clinically on their case. I tried my best to be respectful of the boundaries of the relationship.

I often found myself anxious about challenging the therapist's perspective on the case. For example, in one case, I found the therapist defensive in the initial phone contact when the therapist immediately gave me a definitive formulation of the suicide. During the interviews, I developed a rather elaborate fantasy that the therapist was wearing a wig and was dying of cancer. I found myself paralyzed, unable to question any aspect of her narrative. This seemed to represent my perception that she was extremely fragile and could not tolerate any other perspective on her case. And that I would symbolically kill her, were I to challenge her beliefs about her patient. This was an extreme example, but in most of the interviews, I felt significant anxiety about entertaining thoughts that would challenge the therapists' beliefs about the case. In particular, I felt that the therapists often idealized their relationship to the patient, idealized themselves as therapists and idealized the patient. I often felt intense anxiety about challenging that idealization. It is possible that I experienced my separateness, my separate mind and alternative views, as potentially threatening to the good rapport with the therapist.

It is also possible that my experience of being frightened to voice an alternative perspective reflected a parallel process to the original therapy dyad. Perhaps, therapist and/or patient had felt unable to challenge the other and question the idealized relationship.

As I interviewed more therapists and became more comfortable with the interview process and with the development of my ideas, I simultaneously found the therapists I interviewed less defensive. The therapists interviewed later seemed willing to struggle with different perspectives on their case and I do think this was directly correlated to my comfort level presenting my ideas. I never got completely comfortable challenging therapist's beliefs about the case.

The therapists were often very complimentary at the end of the interview towards me, specifically for putting them at ease and listening to their perspective. While I do think a good rapport developed with each therapist, I was left with a sense that I was idealized. When the therapists complimented me on my "goodness," I often felt anxiety about my "badness." In this case, my "badness" was that I was busy developing ideas about the cases that I was not sharing openly.

I felt that the therapists continued to struggle with the most difficult aspects of the therapeutic task. I developed an enormous amount of respect for them. The openness that occurred in the interviews spoke to their pursuit to better themselves and to better their work.

Descriptive Data about the Patients, the Therapists, the Treatments and the Suicides

In the following sections, I will summarize what I learned about the patients, the therapists, the dyads, the treatments and the suicides. This is meant to provide background data for the section that follows where I present the central themes found in the data.

The Patients:

I interviewed 10 therapists about 12 patients (7 females, 5 males). Two therapists were interviewed about more than one patient. The patients ranged in age from 21-45. In terms of diagnosis, 6 were diagnosed as schizophrenic, 4 were diagnosed as borderline, 1 was diagnosed as borderline/manic depressive and 1 was mentally retarded with undiagnosed mental illness. In terms of intelligence (therapist's assessment), 1 was of below average intelligence, 7 were of average intelligence or above, 4 were of above average intelligence. 6 had less than college education, 3 had bachelor's degrees and 3 had graduate degrees (2 Ph.D.'s and 1 M.D.).

There were a high number of patients with coexisting medical and mental problems. 5 had serious coexisting conditions such as epilepsy, juvenile diabetes and severe dyslexia. 2 had serious disabilities from prior self-destructive acts. 1 patient had tardive dyskenisia from anti-psychotic medication.

Prior self-destructive behavior was evident in 7 patients. 2 had made severe suicide attempts (both overdoses). 3 had performed severe self-mutilation (cutting, burning and amputation). 3 had histories of dangerous behavior (poor disease management, assaults, unprotected sex).

Schizophrenics:

A few interesting points can be noticed when the patients are looked at in terms of diagnosis. Of the schizophrenics (6 total: 3 male, 3 female), 3 had unremitting delusions and hallucinations occurring on a frequent basis which were upsetting and intolerable to the patient. These symptoms were not affected by medication.

In terms of relationships, 1 patient was recently married, 2 had significant love relationships and 3 had no relationships. In 4 cases, the therapist was the primary support for the patient

. 2 schizophrenic patients came from upper, middle class families with successful parents and siblings. Although they were seen as potential achievers prior to the onset of their illness, they were unable to achieve at the level of their siblings and parents because of their symptoms. 3 of the schizophrenic patients came from poor/ working class families. In these three cases, the patients all stood out from their families as having shown early potential for some kind of achievement.

An important observation about the schizophrenic patients is that there was an enormous range in each patient between his/her highest level of functioning and his/her lowest level of functioning. The areas of high functioning may be very important in terms of the therapy relationships these patients developed. The high functioning areas may explain to the patients' capacity to form a therapeutic relationship. The range of functioning may have also appealed to the therapist, giving the therapist hope that the patient could improve. The therapists who worked with the schizophrenic patients all had experience working with this patient population. In each case, the schizophrenic patient was described as distinct from the larger schizophrenic population. They were noted to be more related, engaging, and charming. They were also seen to have more distance from

their illness and symptoms than other patients, more awareness of their distress and more awareness of "missing out" on a normal life.

2 of the patients were seen in private practice, 2 in a group home, 1 in inpatient hospital unit and 1 in a clinic specializing in schizophrenia research.

Non-schizophrenic patients:

Of the non-schizophrenic patients (4 female, 2 male), 4 were diagnosed by their therapists as borderline, 1 borderline/ manic-depressive and 1 was mentally retarded and undiagnosed. I am going to leave the mentally retarded patient out of the following summary because this patient was an outlier in terms of age, intelligence and functioning. He does not fit into this group of patients.

As in the population of schizophrenics, this group of patients was characterized by discrepancy in their highest and lowest functioning. All had areas of very high functioning. Areas of high functioning usually centered around career and academic success. 2 were seen by their therapists as "stars" in their respective fields and their therapists noted how well the patients were able to succeed in spite of their severe difficulties in other areas. 2 were seen as effective in their careers, but significantly limited professionally by their pathology.

Relationships were an area of difficulty for all, but all patients had been involved in relationships. (1 separated, 1 engaged, 1 in a long-term affair with a married person, 2 in multiple short term relationships). All love relationships were volatile and a major focus of the therapy work.

2 of the patients were seen in clinic settings and 4 were seen in private practice.

The Therapists:

I interviewed 10 psychotherapists (5 male, 5 female). They ranged in age from 36-68. The suicides occurred throughout the career. 6 of the 12 suicides occurred either during the therapist's training or in the earliest phases of the therapist's career. In the remaining cases, 4 of the therapists were in practice for more than 10 years (ages 38-51), and 2 of the therapists were in practice for over 25 years.

The time elapsed since the suicide at the time of the interview ranged from 3 years to 25 years. (Note: the parameters of the study did not allow me to interview anyone who had experienced the suicide within 3 years of the interview.)

In terms of training, 6 therapists were clinical psychologists (Ph.D.), 1 was a counseling psychologist (Ph.D.), 2 were social workers (M.S.W.), 1 was a psychiatric nurse. All but one were trained psychoanalysts by the time of the interview, but 3 were not psychoanalysts at the time of the suicide.

When asked to specify their theoretical orientation, the 9 analysts identified themselves as psychoanalytic-relational (5), self-psychologist (2), psychoanalytic-Kleinian (1), psychoanalytic (1). The one non-analyst described himself as psychodynamic.

All 10 of the therapists were currently working in private practice. 6 were supervisors at graduate programs and psychoanalytic institutes. 5 were faculty at psychoanalytic institutes. At least 4 of the therapists had published papers in the field.

At the outset of the study, I wondered how the suicide had affected the career path of the therapist. In most participants, I was unable to identify the impact of the suicide in the career path of the therapist. All of the therapists acknowledged that the suicide had had a great impact on them, but none of them really felt the suicide had altered their career path. Only one therapist said she would never knowingly take on a suicidal patient again. Another therapist said she would never take on a borderline patient again. The therapists who were working in clinic settings, all left the clinic and hospital work. They all said that they had never planned on staying in a clinic setting. A few showed a wistful sort of remorse that they had been unable to continue to work with the most disturbed patients and a strong admiration/idealization of those therapists who devoted their career to working with the most disturbed patients.

I did notice that some therapists felt much more positively towards their work than others. I would say that 4 of the therapists showed a positive enthusiasm and enjoyment of their work. They expressed some frustrations, but seemed mostly to feel pleased with their professional life. The rest of the therapists spoke much more about their ambivalence towards the work. They focused on their frustration with their income, collecting fees from non-paying patients and insurance companies. Some felt burdened by patients' demands or questioned their effectiveness as therapists and the effectiveness of psychotherapy as a method. Some expressed more interest in other therapies including medication and bodywork. A few therapists seemed to be struggling with significant feelings of professional frustration and depression. The level of professional depression did not correlate to the therapist's level of success or recognition in the field. Many of the

therapist's who expressed enormous ambivalence were quite successful and held supervisory and faculty positions.

I was not able pinpoint the impact of the suicide to the therapists' careers. However, I suspect that the suicide was not the definitive factor in the therapist's feelings about their work. Like any trauma, the level of injury seemed to correspond with how much the trauma fit into the whole environment. In other words, if the therapist generally felt effective with patients and enjoyed the work, then the suicide was a painful, singularly traumatic event that highlighted the difficulties of working with patients and the vulnerabilities inherent in the therapist's role. They talked about the suicide and the ever present possibility of suicide in a total context of the depressing limitations of analytic work. They thought of suicide as forcing them to confront the painful realization that they were not omnipotent either to control patient's lives or to avoid making mistakes in their work. But in the face of these limitations, they still found value in the work and felt effective.

If the therapist felt a more generalized dissatisfaction with the work, then the suicide fit into negative feelings about patients and about the work. These therapists had a variety of reactions. Some talked about their struggle to accept their lack of omnipotence, but I did not believe that they had been able to integrate this into their practice. Others seemed blatantly resentful and bitter about of their lack of omnipotence. Yet others seemed to be ever striving to prove their omnipotence. Omnipotence became one of the biggest themes in the study and I will address it further later.

One interesting finding was how few therapists had ever sought a formal consultation to discuss the suicide. Many therapists had participated in an initial case

review if they were in a clinic. But most therapists felt that this occurred in phase of traumatic shock, before they were really able to reflect on the experience. Many therapists participated in informal consultation with colleagues right after the suicide. But many times, the colleague was directly involved with the case. For example, the colleague was medicating the patient. Only one private practice therapist sought out a private consultation to discuss the suicide. One additional private practice therapist did an extensive case review with two colleagues.

I suspect that the majority of the therapists were motivated to participate in the study in part because they felt an internal push to revisit the experience. When the immediate traumatic phase had passed, for a variety of reasons, they had not revisited the suicide in a systematic way. The therapists who were in analysis during and after the suicide felt they had not really addressed their feelings from the suicide in their own treatment.

Therapists' feelings about the suicides of their patients seemed to exist in an odd place between the personal and the professional. Intense feelings about the suicide and the patient were not discussed in the professional realm. But neither were these feelings discussed in the therapist's personal relationships or the therapist's analysis. The interviews allowed the therapist's to air all manner of feelings towards the patient. Oftentimes, the therapists were surprised at the depth and passion of their feeling and noted that they hadn't really fully explored the feelings elsewhere. I often felt the interviews just began to tap into the therapists' feelings and I observed the therapists begin to associate to the feelings and make connections to other important relationships

and experiences in their lives. I left the interviews not knowing how much further the therapists would take this exploration.

What do we know about the treatments?

The treatments examined in this study had a duration of 3 months to 15 years. (3 months, 6 months, 1.5 years, 2.5, 3,3.3.5,6,6.5,7,15 years). The patients were seen from once a week to five times a week. 4 patients were seen once a week. 4 patients were seen twice a week. 3 patients were seen three times a week. 1 patient was seen 4-5 times a week. All the once a week therapies took place in clinics.

In several cases, there had been changes in the frequency, both increases and decreases. 3 of the patients regularly were given extra sessions when they were distressed. 3 regularly called therapist when they were distressed.

When asked how frequency of sessions was decided, clinic therapists responded that the frequency was dictated by the clinic or the supervisor. In the private practice cases, therapists who saw the patients twice a week indicated that the patient had chosen to come twice a week. In many cases, the patients were not encouraged to come more often than twice a week. A few therapists said this was not financially feasible for the patient and therefore was not discussed.

The therapists who saw patients three or more times a week were explicit that they chose to do that because they believed that the frequency of the treatment was critical to helping the patient.

What do we know about the suicide?

The patients killed themselves by a variety of methods. Since method has often been associated with gender in the literature, I have included the gender with the method.

Gun	3 (1 female, 2 male)
Jumping	3 (3 female)
Pills	2 (2 female)
Explosives/ Immolation	1 (1 male)
Car Accident	1 (1 female)
Hanging	1 (1 male)

3 patients killed themselves on weekdays, 4 on weekends, 1 on the therapist's vacation, 2 during the patient's disruption of the treatment. 2 killed themselves on a public holiday.

A variety of possible triggers were known to the therapists. At least 4 of the patients had fights with their mother or significant other within a few hours of the suicide. 3 may have been responding to loss (pet's death, therapist's vacation, aborted pregnancy). 2 had both a fight and a loss.

In 5 cases, the therapist knew of no clear trigger. These five patients were all schizophrenic. One explanation of this finding would be that the triggers for schizophrenic patients are more likely to occur internally, rather than manifest themselves in the interpersonal context.

All of the therapists except one were surprised by the suicide. However, they were surprised for different reasons. Some never thought the patient was capable of suicide and some were more surprised at the timing. In terms of suicidal communication, there were

three groups: patients that never communicated suicidal intentions, patients that communicated suicidal intentions at other points in the treatment and patients who were discussing suicidal feelings near the time of the treatment.

6 of the patients had never mentioned any suicidal feelings or intentions. However, one of these patients had made a serious suicide attempt before the treatment and the therapist acknowledged in the research interview that it was very likely that past and present suicidal feelings were collusively left out of the treatment dialogue. Two additional therapists in this group felt that their patients must have experienced suicidal feelings during the treatment and they were disturbed knowing that these feelings went undiscussed. Two therapists believed that their patients had committed completely impulsive acts of suicide and that the patient had not hidden any suicidal feelings during the treatment. Upon reflection, one of those therapists considered the possibility that the patient had hidden suicidal intentions from her and she began to hypothesize about what that indicated in the transference. The other therapist could not consider that the patient may have planned the suicide, in spite of significant evidence that the patient had planned the suicide well in advance.

5 of the patients had communicated suicidal feelings at other times in the treatment, but not immediately prior to the suicide. Mostly, they had communicated suicidal feelings when they felt depressed, despairing or when they were experiencing intense conflict with others outside of the treatment. One schizophrenic patient had communicated, "I have to be careful, because I could be capable of killing myself or someone else in response to [hallucination]."

Only one patient had communicated suicidal feelings within a few weeks of the suicide. The therapist was unable to remember the communication. The therapist only remembered that the patient had made explicit at that point that she would not contact the therapist if she wanted to kill herself.

One significant finding is a finding of absence. There was not one case where a patient had committed suicide during a moment of intense overt conflict with the therapist. Two patients had interrupted treatment or missed sessions, but without expressing anger directly at the therapist. Other reasons were stated for interrupting the treatment and those reasons were accepted by the therapist.

CHAPTER FIVE

THEMATIC ANALYSIS

In this section, I will present the central themes derived from the data. First, I will present the basic pattern of themes that were found in nearly all cases. Then I will present a brief description of four cases and show how the themes manifest themselves in each case.

Before I attempt to consolidate the data and present the critical themes that emerged from the data, I would like to clarify what I did not learn from this study. One striking finding was that I did not get a vivid sense of the patients. Most of the time, I got a sense of how the therapist felt about the patient, but I could not say that I developed strong portrait of the patients in my mind.

I did not find out why the patients committed suicide. Although I have tons of data, in the end analysis, we do not know why the patient killed his or her self. We cannot know what went through the patient's mind in their final moments or how impulsive or how planned the suicide truly was. We also cannot know about the fantasies that were acted out in the suicide. Of course, we do have some data to construct hypotheses and this data should not be ignored, however it can never be verified without the patient. I also do not know how this pool of patient fits into the larger group of patients who commit suicide in treatment.

Themes emerged from the data that will be explored in this section and the following discussion. These themes often reflect the dynamics that were taking place in the treatments prior to and at the time of the suicide. We cannot know how relevant these

themes are to the suicide. Even when we can identify important enactments in the treatments, we cannot say the patient would not have suicided had the enactment been understood. Sometimes, we could even wonder if certain enactments kept the patient alive for longer.

Many of the themes will address intense transference-countertransference relationships that were taking place in the treatment. Even with thorough interviewing of the therapist, we cannot use the data about the countertransference to evaluate how the particular therapist functions with patients because we can only look at the therapist's functioning in one dyad. Thus, we cannot really evaluate whether unanalyzed countertransference is a norm for the therapist or something elicited in the particular case.

Three findings were immediately apparent in the data set.

1. **All of the therapists reported a good relationship with the patient.** All of the therapists felt that they had established a strong emotional connection to the patient and that they worked particularly well with the patient over a long period of time.

2. **Most therapists were surprised by the patient's suicide.** In none of the cases did the patient openly talk to the therapist about suicidal feelings and plans just before the suicide. In 8 out of 12 cases, the therapist was completely surprised by the suicide. In 3 additional cases, the therapist was aware of the patient's suicidal tendencies, but was not particularly concerned at the time of the suicide. In only 1 case, the therapist was concerned about the patient committing suicide imminently because the patient had missed multiple sessions.

3. **None of the patients attempted to contact the therapist when they were on the verge of committing suicide.** Almost all of the patients had arrangements where they

could contact the therapist outside of the therapy hour. Most of the patients could have seen the therapist within 24 hours of the time of the suicide.

Development of the Themes

Significant questions were evoked by these preliminary findings. How does it come to be that the patient makes a critical decision without consulting the therapist? Many therapists were absolutely shocked and quite devastated to discover that their patients had kept so much out of the therapeutic dialogue. Most therapists believed, prior to the suicide, that they knew their patients thoroughly. Some therapists struggled to recognize how much they didn't know or understand about their patients. Other therapists insisted that they knew their patients completely and could not face evidence that contradicted that belief.

If a patient can keep critical experiences out of the therapy dialogue, then what does it mean to have a "good relationship" in the context of a therapy relationship? Do suicides occur in a good therapy relationship? What defines a good therapy relationship? Obviously, it is not simply that therapist and patient like each other. In the cases I heard about, the therapists spoke movingly of their deep emotional connection and love for their patients.

These findings, apparent immediately in viewing the data, created the focus of my data analysis. The pattern that emerged from the data suggested that I look at the total relationship that had developed between therapist and patient. If at the time of the suicide, the patient was not using the treatment to discuss suicidal feelings, what was the purpose of the treatment? What had the treatment relationship come to mean to the patient? What

had the treatment relationship come to mean to the therapist? How did the therapist feel the patient was being helped by the treatment? What may have prevented the treatment being used to discuss critical experiences in the patient's life?

A basic pattern emerged from the data that can be identified in each case. A positive connection formed immediately between patient and therapist and both parties harbored big hopes for the treatment. In each case, the relationship became idealized. In each case, for complex reasons to be explored further in the case examples, the narcissistic aspects and the defensive aspects of the idealization were never recognized. Although the analytic task was often stymied, the relationships were sustaining for a period of time because the therapist and patient enjoyed the relationship. The patient often made limited, but significant improvements in their external life at this time. These improvements fueled the therapist's idealization of the relationship. The patient's negative transference was never fully experienced in the treatment. In subtle ways, both patient and therapist avoided exploring the negative transference, although there is always evidence that the negative transference was at play in the treatment. Over time, the patient's intense fears of the patient's negative transference are inadvertently reinforced by the treatment.

In all of the cases, there were signs that both patient and therapist lost hope in the treatment. The patients may have become hopelessly aware that the therapists would never gratify the wishes towards the ideal object. The patients had not developed hope that the therapist could help the patient through the painful de-idealization through an analytic involvement. The patient had not developed hope of achieving more control over his or her life through a better understanding of his internal world.

There were signs that the therapists lost hope in aspects of the therapeutic process prior to the suicide. Therapists lost hope that the patient could be helped through an analytic involvement, but maintained hope that the relationship was good for the patient. Often the therapist's hopelessness was manifested in a decision to take on a primarily supportive role towards to the patient.

In most of the cases, the therapist had given up exploratory work with the patient by the time of the suicide. The patient was not seen as capable of making further progress through a deepened understanding and working through of the patient's conflicts and the patient's dreaded, intolerable states of mind. The patients were understood as needing an ongoing supportive relationship. The therapists hoped to help the patient construct a life that would avoid the experience of the patient's vulnerabilities. Supportive measures helped reinforce patient's defenses, but may have increased the patient's fear and intolerance of negative states of mind.

The goals of the treatment at the time of the suicide were vague. Many of the therapists were anxious about ending the treatment and anxious about the patient's dependency. When asked about the expected termination of the treatment, therapists either felt the patient would be in treatment indefinitely or the therapists had vague notions of how the patient would eventually function well enough to leave treatment.

At the time of the suicide, most therapists believed that the patient had made significant progress. Some felt that the patient had not made enough progress, but these therapists did not question the treatment. Only one therapist at the time of the treatment was concerned that the patient's progress had been superficial and was consciously questioning the treatment and receiving consultation.

An Examination of the themes:

The following themes will be examined in several cases:

I. Hope and Hopelessness
II. The Idealized Relationship
III. Intolerable Experience
IV. Omnipotent Fantasies and Fear of Separateness
V. Physical and Emotional Availability of the Therapist

An additional theme will be examined briefly, only in terms of clinic cases.
VI. Termination in the Clinic Setting

I. Hope and Hopelessness:

The evidence suggests that both patient and therapist felt hopeful about the treatment early on. In all of the cases, the therapist believed that the patient had the potential to benefit from therapeutic work and believed that they had formed a strong therapeutic alliance with the patient. It seems that the intensity of the emotional connection evoked hope in both participants.

The therapist's shift to hopelessness was apparent in most cases, but often was not conscious to the therapist at the time of the treatment. Sometimes the therapist became aware of their hopelessness during the study interview. In terms of this study, hopelessness is understood as any action on the part of the therapist that suggests that the therapist no longer believed that psychological understanding could be used to help the patient. This can be seen when therapist became more focused on medicating the patient, giving supportive counseling and advice to the patient, including relationship advice and career counseling. Therapists often maintained hope that the relationship itself would be sustaining, regulating and therapeutic for the patient.

II. **The Idealized Relationship**:

The patient and therapist began working together and developed what the therapist felt was a good working relationship based on a strong emotional connection. The therapists often described the relationship as a particularly good match where the patient and therapist "clicked" immediately. An inflexible narcissistic connection between patient and therapist solidified, based on the particular character proclivities of the individuals involved. The patient felt cared for and often received special treatment and adjustments in the treatment frame. The way in which the patient gratified the therapist's narcissistic needs varied from case to case. In simple terms, the patient and therapist made each other feel good. The therapist often felt helpful, generous and empathic in the relationship with the patient. Some therapists were able to identify how they may have been caught up in a mutually enacted narcissistic relationship with the patient. They suspected that the relationship felt good, but the patient did not get better or got better as an aspect of pleasing the therapist. In fact, the patients often made significant life improvements, appeared to function better and be more organized. However, these improvements were mostly in the areas of work and superficial mood stability. In intimate relationships, the patients made little or no progress. In most cases, the patient's improvement was understood by the therapist as significant therapeutic progress. Only one therapist suspected at the time that the patient's external improvements were not accompanied by internal change. That therapist had sought out consultation.

Therapists were not aware of negative feelings towards the patient prior to the suicide. Upon reflection, some therapists recognized pity as a predominant feeling towards the patient.

III. Intolerable Experiences

Certain intolerable experiences can be identified in retrospect that did not become the subject of analysis in the therapeutic dialogue. Intolerable experiences were avoided by both patient and therapist. The term "intolerable experience" will be used (instead of bad object) in an attempt to express the subjectively intolerable nature of the avoided experience. The intolerable experiences were subjectively intolerable to both patient and analyst. In essence, the intolerable experiences became the bad object of the treatment dyad. The therapist and patient may have successfully negotiated many difficult emotional experiences and confronted many of the patient's bad objects in the transference. However, some experiences proved intolerable to the dyad and were either never discussed or projected into a person outside of the treatment, such as a hated parent or ex-spouse. The attributes of that person were reviled by both patient and therapist. In fact, patient and therapist often bonded over a mutual hatred of an individual or an experience. Neither the patient's, nor the analyst's identifications with the hated object could be tolerated and analyzed.

The intolerable experience is understood in this study as a set of feelings and ideas. Yet, in the treatments studied, these feelings were unconsciously associated with death and destruction. The intolerable experience was avoided by both patient and therapist as if there was a bomb detonator in the treatment room that could never be touched. It became unspeakable and unanalyzable because neither party recognized the

deadliness as fantasy. The therapist's stance towards the intolerable experience may have confirmed the patient's intense fears and need for extreme defenses.

In clinic cases, the unspoken, intolerable experience was the therapist's impending abandonment at the end of the therapist's tenure at the clinic. Therapist and patient were usually unable to discuss openly the possibility of the therapist's abandonment of the patient. It is not only the patient who feared the therapist's abandonment, but the therapist who could not tolerate imagining him or herself as an abandoner of the patient. This ever-present and important issue went unaddressed.

IV. Omnipotent Fantasies and the Fear of Separateness:

Omnipotent fantasies of patient and therapist were often manifested in the cases. Omnipotent fantasies were enacted by the therapist when the therapist attempted to control the patient, manage the patient's life or protect the patient. Sometimes these behaviors were rationalized by the therapist's belief that the patient needed supportive measures due to the patient's diagnosis. The therapists' omnipotence often appeared when the therapist believed that they had to be constantly available to the patient.

Many therapists seemed to be in a constant struggle to maintain a kind of perfect empathy towards the patient. The therapist's omnipotent strivings, particular the therapist's desire to be perfectly empathic seemed to fuel the patient's expectation that therapist provide a perfect environment. Some patients in the study demanded modifications in the treatment, extra sessions, reduced sessions, or reduced fees. The therapist often acquiesced to the patient's demands with the understanding that they were doing what the patient could tolerate. However, the therapists often seemed to believe that they should be able to make the treatment tolerable for the patient as if they had the

power to make the treatment tolerable for the patient. When the treatment was modified, the nature of the patient's wishes often went unexplored. For example, the patient complained that he or she was upset and received an extra session, but the patient's wishes to have the therapist be more available or the patient's sexual or merger wishes towards the therapist were not explored. The patient's request was taken at face value and granted. It seems that the patient then achieved a feeling of control in the treatment that inhibited a fuller exploration of the patient's experience of the limits of the treatment. The patient wasn't given the opportunity to experience the lack of control the patient has over the analyst and the opportunity to mourn the wish for omnipotent control over the other. Lack of omnipotence was a common intolerable experience avoided by both patient and therapist.

The patient's feelings about experiences of separateness often went unanalyzed when the treatment was ruled by omnipotent fantasies of both parties. Patients often manifested intense anxieties about separateness. It is impossible to know the underlying fantasies of the patient's suicides, but there is evidence that the patients might have been attempting to obliterate feelings of separateness in the suicide by achieving a fantasied reunion with a perfect, idealized mother.

V. The Physical and Emotional Availability of the Therapist

In many of the cases, the patient and therapist were meeting on a regular basis and yet, the patient did not discuss the suicidal plan with the therapist. Only one therapist was on vacation at the time of the patient's suicide. The therapists were physically available to their patients. In fact, seven of the patients had special arrangements where they could have additional sessions or phone contact. Many of the therapists felt reassured after the

patient's suicide because they felt they had been available to the patient and this alleviated their guilty feelings.

The question this study must contend with is whether the therapist was psychically available to engage with the patient in a therapeutic process at the time of the suicide. What does it mean to be available to the patient? No matter how available the therapist is to the patient, the relationship always has limits. First, because the therapist is a separate person and has a separate mind and can never be as perfect as the patient might want. Additionally, the therapist is only available in the role of therapist to the patient. The therapist is by definition, not available to the patient for other roles, such as parent, lover or friend. The therapists in the study were often unable to recognize how unavailable they were in the eyes of the patient. The patient may have wanted not only more sessions and more contact, but the patient may have wanted to alter the relationship and create a parent-child relationship or a love relationship. When the therapist does not recognize these desires as an intensifying transference, the therapist is, in fact, psychically unavailable to the patient. In many cases, the therapist acquiesced to the patient's stated demand and foreclosed the opportunity to discuss the patient's potentially deeper wishes.

At times, the therapist offered the patient extra sessions when the patient was distressed, but the therapist did not insist that the patient increase the frequency of scheduled sessions. Many of the patients in the study were being seen twice a week, although the therapists felt that the patients were very disturbed. In this situation, the therapist had an image of him or herself as available to the patient, in fact, generously available to the patient. The patient may also have seen the therapist as generous and this

may have increased the idealizing transference. However, this dynamic may have prevented the patient from experiencing and complaining about the limits of the therapy and the therapist. The therapist may have been available as a soothing presence, while simultaneously unavailable to analyze the patient's negative transference towards the unavailable, imperfect and limited therapist.

Presentation of the Cases

Case 2:

A mid career analyst, Dr. H, worked with a young female lawyer, Ms. Z, for more than ten years. From the beginning, the therapist felt optimistic about working with the patient because Ms. Z was bright, articulate and talented. "I think my optimism was in how hard she worked. She did not want to be crazy. She did not want to be paranoid. She did not want to flip-flop and see people as the enemy, to be so vulnerable to injury. She clearly wanted to have a good life and not be ruined by her pathology."

The therapist came to understand her patient as "a very vulnerable borderline." The first few years of the treatment, the therapy relationship was characterized by ruptures and reunions. Dr. H felt she and the patient finally discovered a way of working together. "Her signal transference image was of her mother teaching her how to swim and moving away, so that she would never be able to reach her.....so she had to keep me as steadily mirroring her or she would be frantic....so she suffered enormously."

The analyst felt that the best way of working with the patient was to stay as emotionally attuned to the patient as possible to avoid ruptures. "I struggled and struggled to work with her and to stay empathically attuned to what she was feeling, because she was distressed and humiliated by what she felt. I could always come in and instead of being critical or adversarial or interpretive, which might be considered critical or adversarial...to get with the feeling of humiliation or whatever she was feeling....in other words to come in from the...stay as empathically attuned to what she was feeling as possible. Because sometimes she would be so provocative and make me, Miss Wonderful, into the enemy, that was very hard for me, very hard to not say, would you please cut it out! I could never say that to this patient and have it work. There were one or two times where I lost it. I am ashamed of it, because I slipped out of analytic....she just drove me there and I suddenly slipped out....the work was constantly trying to stay with what she was feeling rather than judging it from the outside."

The therapist avoided ruptures with the patient. "I could never put her as the first patient, ever, why? Because if I was not exactly on time, it was always demeaning to her...and once I learned that, I moved her to the middle of the day, because I could not risk. Do you know how long that could take to heal? One lateness could cause a month's

not talking to me." When ruptures did occur, the patient became abusive towards the analyst. "At times, she would make mud out of me with such viciousness."

Eventually, the patient and analyst worked together for a period of years with many less ruptures. During this time, the patient made many changes in her external life. She advanced to partner in a prominent law firm, married and had a child. During the same time, Dr. H believed that her struggle to be constantly attuned to her patient had proven worthwhile. The analyst presented her work with the patient amongst colleagues as a successful stance with a borderline patient. Dr. H received consistent praise for her work with the patient and was proud of the sustained connection with a difficult patient and the patient's improvements in her external life. The praise Dr. H received from colleagues helped sustain her self-esteem through the patient's constant attempts to demean her.

One major rupture occurred during this phase of the treatment. The patient said to the analyst one day, "I want you to hold my hand and jump into a pool of memories with me." Dr. H hesitated and says, "I'll be with you, but I don't think I can jump right in with you. Someone has got to be watching." This particular rupture led to the patient's refusal to speak to the analyst for a period of several weeks. The patient returned only when Dr. H called her and said she had been thinking of her.

In the last few years of the treatment, the patient's marriage began to fall apart. Dr. H believed that if the marriage had not fallen apart, the treatment would have been terminated by that time. The marriage, which was initially seen as a sign of the patient's improvement, was seen as an unfortunate turn of events. The patient became embroiled in a nasty divorce. The patient became extremely depressed and began taking anti-depressant medication. "She began to really fall apart. I spent most of the time either getting her medicated, or trying to help her deal with the reality that was preventing her by becoming more and more of a supportive psychotherapist, not a psychoanalyst. She was in dire straits." The analyst describes the patient as crying much more during this phase. The analyst did not feel there was any more analytic work to be done but she also felt that she could not abandon the patient at such a difficult moment of the patient's life.

One day the patient missed a session and the analyst discovered that the patient killed herself after a fight with her spouse.

When I first discussed the case with the analyst, Dr. H described the case as a successful case of analysis of a borderline patient. She described the suicide as a "purely interpersonal event" between the vulnerable patient and her spouse. When asked about the success of the analysis, she explained that she felt that the patient had an incurable vulnerability that the patient had learned to deal with as best as she could. Dr. H felt that this vulnerability had been stressed beyond what the patient could tolerate during the fight with the spouse. She felt the suicide was impulsive in a moment of distress when the patient "could not hold on" and no one else was present to soothe the patient back to a tolerable degree of distress. The analyst had particularly strong feelings towards the patient's spouse. Dr. H called him evil, "grandiose, manic, sadistic fine, I don't care about that. But crazy!" The analyst said that she feels she continues to hate the husband for her patient.

As Dr. H reflected on the case further, she began to conceptualize the case in three phases. She describes an early phase full of small ruptures where she came to understand the patient's vulnerability and learned to work with the patient. This was

followed by a middle phase where Dr. H felt they worked together well for years. It was the last phase of the treatment that Dr. H began to reconsider.

"I was uncomfortable in that last phase that it became so supportive, you know, so cutting and pasting, so advice-y. That was a different kind of treatment, but I don't think it could have been avoided, because I would have been abandoning her at a time where she....I don't think it could have been avoided....I was not happy with the turn of events, for her or for the treatment....but you know, I didn't conceptualize it that way at the time. Now I think I see the turn. I think the treatment just became more arduous in that way. It was much more crisis oriented all the time. Also she just cried much more in that phase than in the earlier phases. She was really, really angry at him....the answer to the overall question is I don't think I would have done anything differently. I don't know about the end part. I don't know about the end part because I haven't conceptualized it that way....but in the earlier phases of learning how to work with this patient and the struggle to stay in any empathic connection and not rupture against enormous sabotaging odds on her part. It was very hard."

The analyst also began to wonder whether there was a way that she and the patient colluded in a wish to believe that the patient's marriage was a sign of internal improvement. "Perhaps, it was a folie a deux." Dr. H talked about the difficulty of working with a patient whom she suspected had an insatiable wish to be constantly held and embraced. "My hunch is that that cannot be cured. I think that need is always going to be there. It's insatiable. Maybe that's why she married the guy. Going towards a fantasy of reparation." The analyst continued to feel that the marriage was unfortunate and that she wished life had dealt the patient "a better hand."

Hope and Hopelessness:

It is clear that Dr. H formed an immediate attachment to her patient and felt hopeful long into the treatment that she could help her patient. Even though she struggled constantly to be empathically attuned to her patient, Dr. H still felt she could work well with her patient. When the patient's marriage fell apart and the patient became depressed, Dr. H started to pity her patient. She gave up hope that psychological understanding could help her patient through this difficult time, because she identified the patient's primary problem as an external, interpersonal conflict. Dr. H's shift into a supportive stance manifested her hopelessness.

The patient's hope and hopelessness is harder to know about. It seems possible that the patient felt hopeful as long as she felt she was able to control Dr. H's responsiveness to her because then she could continue to believe that she could create her own perfect object. She tried to create her own reparative object both in the analyst and the husband. However, it seems that the patient became hopeless when she recognized her inability to maintain the desired relationship to the reparative object. She may have been devastated and disappointed, not only at the loss of the husband, but also at the pending loss of the analyst when the therapy finally ended. What would she do when the good object was gone? The patient's hopelessness may have also derived from disillusionment in the treatment. The promise of the idealized perfect object did not prove sustainable. The analyst considered the treatment a success, but the patient may have been aware that her greatest difficulties remained unanalyzed. She was not in a satisfying love relationship. She had not come to terms with the depressing reality that her wish to omnipotently control others, to avoid the experience of separateness and to deny her own sadism could not be satisfied. She succeeded only in talking the analyst out of doing analysis and found herself left alone with tremendous impotent rage. The patient was scheduled to have a therapy session several hours after the time of the suicide. The patient did not feel hopeful that therapy could help her at the moment of the suicide. The suicide was seen as a better solution.

Idealization:

In this case, the idealized relationship between patient and analyst is so strong that many years after her patient's death, Dr. H maintained an unquestioning belief that the treatment was a success and that she and the patient were an excellent match. Obviously,

there was a strong initial connection and attraction to the patient's intelligence and a belief in the patient's desire to live a better life. The patient was idealized, and the danger of the patient's mission to find a reparative object was not fully recognized. The analyst was idealized by the patient as a potentially reparative, good mother. Dr. H was expected to be the mother who gave endlessly and "rose above" endless abuse from the patient without ever retaliating. Dr. H tried to be that ideal mother.

The dyad or the match was idealized as the patient and analyst believed that they had found a way of working together that was understood as an adjustment suited to the patient's vulnerabilities. Out of this narcissistic relationship, the patient gained a feeling of being special. The guilt she could elicit from the analyst confirmed the patient's sense that she was entitled to perfect mothering. Under this kind of mothering, the patient improved in some aspects of her life, but she was still prone to extremely volatile intimate relationships.

Out of this relationship, the analyst gained a sense of being special. She felt she was able to make an extraordinary connection to a difficult patient and she exhibited herself by presenting the case to colleagues and supervisors. The analyst was particularly proud of being able to remain in a nearly constant stance of empathy towards a patient who was often demeaning and abusive towards her. She prided herself on her ability to "rise above it," but she was also self-critical when she "lost it" occasionally towards the patient. This is a strong example of the idealization of the analytic role where Dr. H expected herself to be able to saintly towards her patient. She expected herself to be able to live up to the good mother image the patient wanted.

The problem in this fixed role relationship is that the patient might have believed that she could not live without the externalized good object.

The Intolerable Experience:

Dr. H and her patient shared an idealization of a saintly maternal figure, but on the flip side of this idealization, they also shared an enormous shame about the identifications with the ambivalent, sadistic and abandoning mother. This is the intolerable experience that went undiscussed and unanalyzed in the treatment. And on the day of the suicide, the patient was the shameful, rageful, abandoning mother.

The analyst's intense feelings towards the patient's husband signal that the husband was a repository for some of the unanalyzed, intolerable experiences in the treatment which were collusively projected out of the dyad. The husband was considered evil and crazy and the analyst made it clear that she had no empathy for this man. Although the analyst had next to no contact with the husband, she continued to hate and fear him after the treatment. The husband was considered "bad" in a way that was beyond psychological understanding. On the other hand, when the patient acted abusively towards the analyst or the analyst "lost it" at the patient, this kind of behavior was seen as understandably bad. In this way, neither patient nor analyst came to terms with conflicts over their own sadism. The sadism of patient and analyst was collusively projected into the husband. Then the dyad bonded joyfully over denigrating the hated object. In this relationship, the patient never had an opportunity to explore and come to terms with her own sadism. The analyst made clear to the patient that she had no empathy for that kind of sadism and this may have intensified the patient's shame and guilt about her sadism. After the suicide, the analyst was confused about the patient's sadism. "There's a great

irony. She was an exceptional mother but she abandoned her child in the most horrible way." After the suicide, the analyst struggled to come to terms with her beloved patient as abandoner and murderer.

The experience of separateness was intolerable to the patient. The analyst quickly intuited the patient's inability to tolerate the analyst's separateness and she responded by trying to be constantly empathic to the patient, so that her separateness might be imperceptible to the patient. For a long period of time, patient and analyst worked together as if they were not separate, but the patient's dread of separateness was never understood in a way that she might begin to tolerate it. While the analyst's empathic stance towards the patient may have initially helped the patient create a therapeutic alliance, it turned into a collusive avoidance of the patient's rageful response to separateness. Patient and analyst acted as if they could not survive the patient's experience of separateness. Therefore they had to work to preserve the illusion that they were not separate. Thus the opportunity is lost for the dyad to struggle with the pain of separateness and mourn the wish for a more perfect union.

Omnipotence:

One of strongest recurring themes in this case revolved around omnipotence. Ms. Z tried to maintain her fantasy of omnipotence by demanding that Dr. H be the perfect mother and then torturing, threatening and manipulating Dr. H into keeping to that limited role. For an extended period of time, Ms. Z was able to maintain the fantasy of omnipotence.

Dr. H worked tirelessly to be the object that the patient demanded. Eventually she came to behave as if she were responsible for making the treatment tolerable for her

patient. Dr. H saw herself as able to control and diminish the patient's suffering through her empathy and availability. A relationship developed where the patient felt entitled to abuse Dr. H and blame Dr. H for every disruption. Dr. H tolerated the patient's abuse in a masochistic way that suggests that she felt guilty when the patient was disrupted.

In this relationship, the separateness of patient and analyst was obliterated. When Dr. H asserted herself as separate through interpretation, by being late, or by refusing to jump in when the patient says, "jump in," enormous rage reactions ensued followed by guilty responses by the analyst. In fact, during a major rupture when the analyst hesitated to "jump in", the analyst tried to assert her separateness, but the shift was intolerable for the dyad.

A dilemma existed with the set-up of the relationship. There was no way to imagine the termination of this relationship, because the patient was seen as unable to function autonomously. Dr. H imagined that the patient suicided because "she just couldn't hold on....if someone had been there with her when she got that phone call...to diffuse it....to distract her for a little..." The calming and soothing presence of Dr. H, the idealized object, was not with her and the patient had not internalized a soothing object enough to soothe herself.

Availability:

The patient suicided several hours before a scheduled session with Dr. H. The patient did not call Dr. H at the moment when she decided to kill herself although she had called Dr. H frequently outside of the scheduled sessions when she was in distress.

When central elements of the transference are not being addressed in the treatment, we must ask whether the analyst was psychically available to experience and

analyze the transference relationship. To be psychically available to this patient, the analyst would have had able to tolerate the negative transference that would ensue when the patient de-idealized Dr. H. The patient may have felt that the therapist was only psychically available in the role of the idealized maternal figure.

Case 9:

As a junior psychoanalyst, Dr. K took on a male patient his own age, Mr. F. They worked together for five years, at first twice a week and then later once a week at the patient's request. Mr. F was supporting himself through award money received from a lawsuit. Mr. F came to treatment because he had difficulty maintaining employment due to an explosive temper. Although he was unemployed throughout the treatment, he was able to live well from his settlement.

Dr. K felt an immediate bond to the patient. He found the patient charismatic, engaging and full of vitality. "He was a kind of impulsive, brawling guy who really never found his place in the world.....and I hit it off with him so well....this guy felt very comfortable with me and I felt very comfortable with him....there was just a real chemistry between us....

...I just got a kick out of him....maybe in some ways, he reminded me of my father. He wasn't like that but he was a kind of salesman. A kind of charming guy."

Mr. F believed in a code of behavior, which included loyalty to friends and family. The patient often expressed admiration for Dr. K seeing him as a good father and a good son. He saw Dr. K as someone who made it in the world and deserved respect.

Dr. K understood Mr. F's central dilemma as follows: "what it all revolved around was this guy was just terribly ashamed of himself and who he was. He realized he looked one way but was another way. He could dress nicely. He was good looking. And he lived in a nice apartment. But he felt illiterate, stupid and ashamed of the way his mother had raised him." The patient longed to do something useful with himself and came up with many plans that he never followed through to fruition. Dr. K admired Mr. F's desire to be a productive member of society.

As the treatment progressed, Mr. F went for remediation help and seemed to move towards improvement in his external life. He had a long-term relationship with a woman and reinitiated contact with his child whom he hadn't seen for years.

Mr. F often discussed his dilemma as a search for "a cover story" in his life to explain what he was doing with himself. But Mr. F had a constant anxiety that everyone was wondering how he lived so well and everyone thought he was a useless loser. Mr. F revealed to the therapist that had an ongoing, specific delusion that he was being spied on constantly. This delusion was unremitting throughout the treatment.

Dr. K tried to help Mr. F overcome some of his fears. He interpreted the patient's paranoia by pointing out that Mr. F's negative feelings about himself were projected into others. At one point, Dr. K agreed to accompany Mr. F to a bank because Mr. F was

terrified that he would not manage to fill out the proper forms to open an account. Dr. K pretended to be Mr. F's uncle and Mr. F managed to fill out the necessary forms. Dr. K likened this event to helping an anxious child ride a bicycle for the first time.

As time passed, Mr. F became more and more consumed with his delusion. His relationship with his girlfriend ended and Mr. F also cut off his renewed contact with his child. Slowly, Mr. F became more isolated and reduced his sessions with the therapist to once a week against the therapist's wishes. At one point, Mr. F became so agitated about being spied on that he moved apartments. During that crisis, Mr. F resumed twice weekly sessions. Dr. K pushed Mr. F to try medication, which Mr. F did. But, the medication had no impact on his delusions. Mr. F finally moved and resumed once weekly sessions, but he was increasingly reliant on Dr. K as his only significant contact.

In the last six months of the patient's life, Dr. K worked to encourage the patient to come to sessions that the patient missed more frequently. Dr. K noticed that the patient became severely depressed and isolated. "I remember that in the last six months, my big project with him was to get him to go to an animal shelter and be a volunteer. ...I was sort of offering to do this thing that I had done with the bank and sort of walk him through the ...he was afraid he would be found out, you know, found out that he was a nothing."

The patient missed several sessions in a row although when Dr. K spoke to the patient by phone, Mr. F reassured him that he was fine and would come to the next session. When the patient missed another session and Dr. K wasn't able to reach him, Dr. K made some calls and Mr. F was discovered dead alone in his apartment.

There are several aspects of the treatment Dr. K reflected on during the interview. He talked about the difficulty of treating a patient with such a fixed delusion, especially when the Mr. F demanded to know if Dr. K believed him that he was being spied on. Dr. K responded to the patient that he didn't know and then proceeded to point out to the patient that Mr. F felt the same things about himself that he experienced from those spying on him. "But I was aware that I was finessing. That I was making an interpretation that he could see as identifying this as projection. And I think that there became a kind of collusion between us where he protected our relationship by not keeping on pressing that issue. In other words, he saw value in keeping me as somebody who didn't just think he was crazy. So he didn't keep pressing me."

Dr. K said he felt that he had to question whether he should have hospitalized Mr. F when he became severely depressed. Dr. K still felt hospitalization was not the answer. "I imagined that moment of his being hospitalized with the police as being the end for him. ...I mean I wish I could tell a different end to this story. I'd like my way of treating him to have been the right way. I would like to believe it....that he was different. He certainly was not.

"...it's some level of wishing that our relationship can regulate this control as opposed to going outside our relationship. Which is what I am questioning. I am just doing it for you. No, I don't really think I should have forced him into a hospital."

Hospitalization was the only alternative path Dr. K was able to imagine. When I asked Dr. K where he had hoped the treatment was going, he said, "I didn't think his narcissism or his general world view was going to radically alter. I didn't think he was going to be able to move into the depressive position, which is where a guy like him would really need to move, to really fundamentally change. To be able to...like you were

saying, why is it the end of the world? Can't a person hold a bad feeling? Can they go through the experience of humiliation or whatever? I mean, I think once you can do that, you have a lot more freedom in the world. If you are always trying to avoid that, that's why you end up killing people. I guess what I hoped, I guess what I wanted to have happen, was some modified version of the life he was living to somehow be achievable. Like if he had a different girlfriend who was more dependent on him than this woman was...you know, like a compromise, somehow get some of what he was looking for. You know and accept less than he wanted."

Upon reflection, Dr. K acknowledged that he felt some judgement of the way Mr. F was living his life. "I felt he was underfunctioning. He was clinging to this perception of himself as disabled. There was no reason he couldn't have gone and ....but he didn't, because he wasn't who he really wanted to be which was more along the lines of a Wall St. millionaire than a busdriver."

"Maybe there were ways I was identified with this guy, a little bit of hubris on my part to think that I could pull it off because I was connected to him."

Hope and Hopelessness:

Dr. K felt hopeful early in the treatment because of the strong connection he felt with the patient and the patient's immediate response to him. Mr. F was not someone who was able to easily accept being in treatment and Dr. K felt it was a good sign that the patient felt comfortable enough with him to attend regular sessions. Dr. K also felt encouraged that the patient displayed some openness to thinking about his feelings and considering how his paranoid thoughts manifested his most shameful feelings about himself.

Dr. K's hope shifted later in the treatment. He no longer felt that the patient would be able to function better as a result of psychological change. He stopped pushing the patient to confront his internal world and focused on helping the patient make changes in his external world. He hoped that the patient might find an external situation where the patient wishes were gratified enough that he could survive. Dr. K's stance manifested a hopelessness that the patient might confront his intolerable feelings of shame and humiliation and survive. He hoped to help the patient by helping him create a life where

those feelings could be averted. Although Dr. K believes that one has "more freedom in the world" once one can experience bad feelings and humiliation, he gave up hope that this patient could handle that.

While Dr. K was still hopeful that the patient might find "his place in the world", Dr. K's therapeutic stance manifested a hopelessness in the utility of pursuing change through the patient's understanding of his own psyche. The patient was not considered capable of experiencing the states of mind he found most intolerable and analyzing them. As Dr. K put it, he did not consider the patient capable of entering the depressive position, the exact kind of movement Dr. K felt was needed to really experience psychological change. Dr. K's hopelessness may have been communicated through his stance towards the patient's attendance of sessions. While he pushed the patient to keep his regularly scheduled sessions, he shied away from insisting the patient intensify the treatment by increasing the frequency of sessions.

The patient's hope and hopelessness, as always, are harder to assess. The patient was hopeful enough about the treatment to come for years. The patient worked to maintain the relationship, even when he missed sessions. However, the patient did not tell Dr. K when his suicidal feelings intensified. He didn't attend his sessions. He treated Dr. K like a good friend that he did not want to burden with his problems. He did not seem to have hope that the therapy could help him deal with his intolerable feelings.

Idealization:

The patient idealized the therapist as a good father, a good son and a productive member of society. Dr. K, in turn, idealized Mr. F as a man who valued loyalty, commitment to family and the importance of being a productive member of society. Mr.

F and Dr. K shared certain values and in fact connected over those values. However, the patient was never able to live up to these ideals in his life. He was an abandoning father and an unemployed man living off a lawsuit settlement. Dr. K did not want to see his patient like other hospitalized patients. He wanted to see his patient as "different than that."

Both Mr. F and Dr. K idealized the relationship. Mr. F chose not to press Dr. K about their different understandings of Mr. F's delusion, because he sought to maintain the relationship, rather than chance rupturing the relationship by pursuing an avenue of conflict between them. Again, at the end of his life, Mr. F preferred to reassure Dr. K and maintain the relationship, rather than share with Dr. K the depth of his decompensation and his suicidal intention.

From the beginning, Dr. K sees Mr. F's positive regard for the therapist as a good connection, but he does not recognize it as idealization. Dr. K idealized the relationship by imagining that their weekly contact could be enough to sustain the patient. Even as Mr. F decompensated into a severe depression, neither Dr. K nor Mr. F believed that the Dr. K was not going to heroically help his patient and Mr. F was not going to magically find a place in the world where he could preserve his narcissism. Even though Dr. K was no longer working analytically with the patient, he believed that the patient could improve through his support, encouragement and concrete help in creating a better life.

Intolerable Experience:

Mr. F's code of values, admired by Dr. K, was accompanied by strong feelings of disgust and shame towards the bad father, the bad son and the useless loser. Dr. K understood that Mr. F's grandiosity and narcissism belied intense shame.

At some point in the treatment, Dr. K began to believe, as the patient believed, that the patient's states of humiliation and shame had to be avoided at all costs. These states of mind became associated with death and apocalypse for both patient and Dr. K. When Dr. K imagined the patient being hospitalized, he imagined this as "the end" for the patient. Dr. K had a fantasy that Mr. F would "shoot ten people" on the way to the hospital.

Dr. K and his patient were caught in a belief that the patient's experience of his intolerable states of mind would necessarily end in real death and destruction. The possibility of experiencing the patient's states of mind in the treatment and analyzing the way the experience has been associated with death and violence, no longer existed. Instead Dr. K and his patient colluded in avoiding the detonator switch for the patient's experience of shame and humiliation. Dr. K's stance served to reinforce the patient's defenses, but may have inadvertently confirmed the patient's fears of experiencing intolerable states.

Omnipotence and Fear of Separateness:

Dr. K acknowledged the underlying omnipotent wishes he had during the treatment. He wanted to believe that the connection he had with the patient was strong enough to regulate the intensity of Mr. F's emotional state. He wished that they would not have to go outside the relationship to get help. He tried to help regulate Mr. F's states in sessions, but he also tried to regulate Mr. F's states out of session, like the trip to the bank, and through suggestions and advice about how the patient might create a life that would regulate his states of mind. Dr. K's attempts to manage his patient's life speak to an omnipotent belief in his ability to know what was best for the patient.

Both Dr. K and Mr. F avoided confronting their separateness. This was particularly apparent in how the dyad avoided discussing the difference in their understandings of the patient's delusion. Acknowledgement of their different thoughts and perspectives was not tolerable to the dyad.

Availability:

Mr. F had missed several sessions, but could have contacted the therapist or attended his scheduled sessions. The patient may have felt that the therapist was available as a supportive presence, but not psychically available to experience and analyze the transference relationship.

Case 5:

A senior psychoanalyst, Dr. R worked with young male patient, Mr. N, for five years. Mr. N came for treatment several years after he was diagnosed as a schizophrenic in his first year of a prestigious medical school. Mr. N was extremely intelligent and had shown enormous talent and potential before he was diagnosed as schizophrenic. Mr. N grew up in a wealthy family where both parents and siblings were highly successful. When Mr. N was brought to treatment, he was living a marginal existence and was noticeably disabled from a self-inflicted injury.

Dr. R felt she and the patient made an immediate connection and began working together three times a week. "He was the most engaging guy you could imagine....I loved him. He was so humble.... I remember once he came in and he said to me, could I ask you a big, big favor? And I said if I could do it and he said could you lend me ten dollars and I said would you prefer twenty? And he was the most meticulous person to return those ten or twenty dollars....He was a wonderful guy.....and this guy, he was so kind and he was so generous and he tried so hard to please her [his mother].....he had an infinite patience for other people's follies and other people's problems because he knew.....he despised his parents' values and he wanted to do something with his life....if he wanted to be a therapist, which I think he would have been fabulous at....he was a wonderful listener, he was very bright and he had very good insight."

Dr. R saw the patient as potentially homicidal and suicidal throughout the treatment. She had an arrangement where the patient could contact her at anytime. She remembered numerous occasions where the patient had called her, usually after a particularly upsetting psychotic experience or after a fight with his mother.

Over the course of the treatment, the patient began to make significant improvements in his life. He took better care of himself, began working part-time as an assistant in a home for disabled adults and eventually met and married a young woman.

The patient's family was relieved at some of the changes in the patient's life, but still hoped that the patient could eventually live up to the promise of his life before he became ill.

Dr. R initially saw the patient as striving to live his life "in utter contradiction to his parents' values." Dr. R had strong feelings about the patient's parents and their impact on his life. She felt they could never accept that their son's life would not live up to their expectations and that they tortured him for this disappointment. Dr. R felt satisfied with the patient's progress. "I was satisfied with this progress. Look how much better than that you could support yourself and you love somebody and you are not crazy...I had enormous respect for him. Enormous respect for his struggle." Dr. R did not believe that the patient would ever live up to the expectations his parents had. "No, that's stupidity. He was too damaged." There were some signs that the patient felt disappointed in his life and that once he married, he felt particularly dismayed that he would never be able to provide for himself and his wife.

She felt compassion towards the patient's father, although he was constantly pushing his son to achieve more in his life. However, she felt the patient's mother was excessively cruel and narcissistic. "I couldn't stand the mother. I hated her. Oh well, hate's a big word, but I had utter contempt for the way that she treated her children...I actually never knew somebody of this badness. This woman had children to give her glory. It had nothing to do with what they valued or what they wanted or who they looked up to....it was the glory."

The patient's family constantly researched and suggested new treatments for the patient's illness. Six months before his death, the patient switched medications, at his parents' request. Although Dr. R was hesitant about the change in the patient's medication, she did not feel she could deny the patient the opportunity to try the new medication. Several months later, the patient told Dr. R that he wanted to take a break from the therapy. The patient claimed that he was feeling good and wanted more time to spend with his new wife. He had interrupted treatment on several prior occasions and returned to treatment within a few weeks. Dr. R agreed but became concerned when the patient did not return in the first few weeks. A month after the patient left treatment, he committed suicide in a particularly violent manner that could have killed members of his family and others. It became clear after the suicide that the patient had been planning the suicide for at least a month prior to committing suicide.

Dr. R described how she imagined the suicide. "This is my fantasy, OK? I have no data for this. I think that one day he realized that this was his life, that he would never have a decent job like his siblings. He realized he would want a better life for him and for his wife and he wouldn't be able to provide it. I also had the feeling there was a, 'so there!' to the parents."

Dr. R felt the patient's illness and ultimate death were a tragedy, but she felt she had done her best in the treatment to help the patient. "If I had not been that available I would have felt guilty, I think. But I could in all honesty say that what I had to give, I gave. And if it didn't work, well..."

Hope and Hopelessness:

In spite of the patient's severe ongoing psychotic symptoms, history of self-injury and marginal functioning, Dr. R was hopeful from the beginning of the treatment because of the strong connection she made with the patient. Her hope was sustained through a long relationship with the patient. She watched the patient take better care of himself and create a meaningful love relationship. However, Dr. R's expectations were never that the patient would make a full recovery. While she was never hopeless, she was more focused on maintaining the patient and helping him deal with external difficulties. Dr. R was not hopeful that deepening psychological understanding of the patient's difficulties would significantly alter his psychotic symptoms.

While it is clear that the patient's parents wished for greater results from the treatment, it is difficult to know how the patient felt. Was he satisfied with the results of the treatment? The parents pushed the patient to try a new medication and the patient acquiesced. But the new medication may have stirred hopes in the patient also. He may have once again been disappointed to discover the intransigence of his illness.

Prior to the suicide, the patient terminated his sessions with the therapist. During this time, he was planning the suicide logistically.

Idealization:

Although Dr. R recognized that her patient was extremely disturbed and potentially homicidal and suicidal throughout the treatment, this understanding was not integrated into her description of his character as humble and generous. The patient was always seen as struggling with the high expectations put upon him by his parents. Dr. R imagined that the patient ultimately suicided because he could not tolerate his own lost potential. But it seems that the patient's rage at his condition and frustration at the limits

of therapy went unexplored in the treatment. The immense violence in his suicide was not really understood as an expression of the patient's rage. It was only understood as a reaction to his demanding parents. The patient was idealized and seen as a victim of his parents' narcissism.

Dr. R made herself available to the patient by phone whenever the patient wanted. When the patient asked for breaks in the treatment, Dr. R agreed. She believed that the patient would benefit from more control over his treatment and from constant access to her. While these adjustments were seen as necessary in the treatment of a schizophrenic outpatient, these adjustments undoubtedly intensified the patient's idealization of the therapist. One could question whether the therapist's constant availability, in fact, served to maintain an idealizing transference and deflected the emergence of the negative transference. One remarkable aspect of this treatment is that the patient never expressed negative feelings towards the therapist. A positive transference was maintained throughout the treatment, even when the patient left the treatment for periods of time. The patient's breaks from the treatment were not seen as negative transference manifestations. The patient's disappointment in his life was never explored in terms of frustration with the therapist.

Intolerable Experience:

Dr. R's disgust at the patient's mother's narcissism and cruelty is striking as she never met the mother. The patient must have represented the mother to the therapist as horrific figure. A split was set up. The therapist prided herself on her availability, selflessness and generosity, her ability to "give all she had" to her disturbed patients. She simultaneously derided the mother for her emotional stinginess and self-involvement.

This dichotomy between the good and bad mother was an important component of the patient's internal world.

In the therapist's description of the triangle between herself, the patient and the patient's mother, it seems that the patient's mother was the holder of a host of bad qualities. Narcissism and extreme selfishness are projected into the patient's mother. The therapist held herself apart from the mother and treated the mother as evil and incomprehensible. In this dyad, patient and therapist were not able to explore their identifications with the bad object, because the bad object is not recognized as internal. The therapist may not have recognized her patient's identifications with the bad mother. She also may not have been able to tolerate any of her own identifications with the hated mother. These identifications were intolerable to the dyad and therefore went unanalyzed.

There is no way to tell how the patient was identified with his mother or what role this played in his suicidal character. Nor do we know that he could have benefited from an attempt to analyze these identifications.

It is interesting that the patient suicided when he began to desire a better life for himself and his wife. Perhaps, he discovered the intensity of his own naturally narcissistic ambitions. Perhaps he experienced the identification with his mother's narcissism as shameful and the frustration of his wishes as intolerable.

The therapist was saddened by the suicide, but she was able to tolerate the loss because she feels comfortable that she was available to the patient. However, she felt that she could not have tolerated the anxiety of not having been perfectly available to the patient. She was unable to see herself as in any way identified with the bad mother.

Omnipotence and Fear of Separateness:

Dr. R is an experienced therapist. She knew that she was not able to help every patient and that she could only do her best. In that sense, she was not omnipotent and did not believe that psychotherapy is a perfect method. However, she practiced with the belief that her constant availability was the most critical component of the patient's treatment. The primary focus of the treatment was not on analyzing the patient's transference or deepening the patient's understanding of his internal world. The focus of the treatment was on creating an intense connection and being available for the patient. Of course, these goals are not mutually exclusive. But a lot of the therapeutic potency was located in the therapist's availability.

Availability:

Dr. R's perspective could be criticized as overvaluing the importance of the therapist's physical availability. In this case, the therapist seems to deny how inevitably unavailable she really was to her patient. She was inevitably unavailable to be with the patient all of the time and to protect him from external conflict or internal states of distress. Thus, when the patient experienced his intense disappointment at the state of his life and rage at the limitations of therapy to help him, he may have felt the therapist was unavailable to experience and tolerate these states.

It also seems that the therapist cannot stand to be perceived as unavailable or unhelpful. The patient may have wished to protect the therapist from his compiaints knowing they would hurt her.

The Fantasy of Termination in Clinic Cases:

In the clinic cases, the fantasy of termination was found to be particularly relevant. When I asked therapists how they imagined they would terminate with the patients, I found that therapists had often not conceptualized the end of the treatment. Sometimes they did not know how long they would be at the clinic or how they would handle the treatment if they left the clinic. Some therapists planned to move the patient into their private practice after leaving the clinic, but had not really discussed that plan with the patient. It became apparent that the therapists were quite anxious about termination and had not fully conceptualized the ending of the treatment because it required them to consider the possibility of abandoning the patient. Anxiety about abandoning the patient was present in all of the clinic cases. Perhaps, it would be true of all clinic cases in general, not simply those where the patient suicided. The possibility of the therapist's abandonment might have been particularly important, however, to these patients. Simultaneously, the possibility of abandoning the patient might have been particularly difficulty for the therapist to hold in mind when working with a disturbed, vulnerable patient. I found in clinic cases, the possibility of the therapist's abandonment became an unspeakable fantasy in the treatment that patient and therapist collusively avoided experiencing and analyzing.

I asked a therapist who was working with a schizophrenic patient in a group home when she thought she would stop working with him: "That I never really allowed myself to think about and it was a big conflict for me to leave there." When I asked her later what she felt would happen in the future, she said, "I don't want to go back to that. I don't want to think about it....maybe I hoped Ms. T (a social worker) would work with him...maybe I would have taken him into my practice....funny, I don't remember

thinking about it." The therapist worked with the patient for several years and yet, they never discussed what the future might hold for the relationship. The patient had been living in the group home for sometime and had been in treatment with several other therapists. The patient must have anticipated that he would be abandoned eventually by this therapist too. The therapist felt that this patient would need ongoing treatment throughout his life. Thus, her anxiety about abandoning this needy patient must have been quite high.

It is also possible that the therapist's stance towards the patient may change when the therapist feels that the treatment cannot be maintained. In one case, the therapist arranged for a patient to continue treatment in the therapist's private practice. Because of distance, however, the patient would only see the therapist once a week when the therapist left the group home. The patient was accustomed to three sessions a week. The patient committed suicide several months before the therapist left the clinic. When the therapist reflected on the treatment, she noticed that her stance towards the patient may have changed in the months prior to transferring the patient to her private practice.

"Yeah, because what was she going to do coming in once a week? How could I do anything else but caretake? To kind of open it up and start to get into it and then leave her? And she doesn't have access to me until a week later. Especially if there is anything we talk about. That was the beauty of me being there [in the group home]...I couldn't open her up and send her away once a week"

The therapist realized that she had begun to shift her stance with the patient away from an analytic stance and towards a more supportive, caretaking stance because of the impending change in the treatment frame. As discussed earlier in this section, the shift

from an analytic stance to a supportive stance may communicate hopelessness to the patient. The patient may have felt that the opportunity for her to make progress through a deepening understanding of herself had ended. She may have also felt that the reduction of sessions amounted to being abandoned by the therapist. We cannot know what the patient's fantasies about the reduction in sessions and the move to the therapist's private practice. However, in view of the therapist's complex feelings about leaving the group home, abandoning other patients and reducing sessions with this patient, the therapist may not have been emotionally available to fully explore the patient's feelings and fantasies about abandonment.

This study suggests that therapists in clinic settings might experience more than normal difficulty exploring the patient's fear of abandonment due to uncertainty about the longevity of the treatment. This topic could be further explored in another study. In this study, the finding is significant because it fits the pattern of the other cases. A crucial experience is perceived as intolerable to both patient and therapist. Therefore it is not explored and analyzed.

CHAPTER SIX

DISCUSSION OF RESULTS

I. Introduction

In the introduction to the study, I suggested that I would not have any definitive answers by the end of the study. This has proven true. And yet, it would be false to deny that I have developed opinions on the following central questions. What role did the treatment play in the suicide? What role did the therapist's countertransference and character play in the treatment? What about the patient's pathology might have made them a particular risk for suicide in treatment? Why didn't supportive treatment work in these cases? In the first part of this section, called "Tentative Answers to Difficult Questions," I will try to lay out some tentative ideas in regards to each question.

In the second part of this section, called "What Can Be Learned from this Study?," I will try to develop further some of the implications of this study and suggest areas for future exploration.

II. Tentative Answers to Difficult Questions:

What role did the treatment play in the patient's suicide?

In the Results section of this study, I tried to show the prevalence of omnipotent fantasies in the treatments studied. It would be an omnipotent fantasy to believe that psychotherapy can create a suicide. I prefer to think about what role the treatment and the therapist played in the patient'suicide.

I have suggested that the results indicate that the patients were very involved in their treatments and had developed intense transferences to their therapists. It is important to try to understand the patient's suicide in terms of transference.

To demonstrate how we can understand the role of transference in patient suicide, we can compare it to suicides in other contexts. For example, in a colloquial terms, we might say, 'he killed himself because his wife left him.' If we look at it in terms of transference, we should say, more accurately, 'he killed himself because of the meaning that his wife's leaving had for him.' 'He killed himself because he lost his job' becomes 'he killed himself because of the meaning that the loss of his job had for him.' This difference in conceptualization leaves room for the unknown fantasy involved in the suicide. Thus we could say, 'the patient committed suicide because the therapist went on vacation,' but we must understand that we mean, 'the patient committed suicide because of the meaning the therapist's vacation had for him.'

In the cases studied, the patient and the therapist were unable to explore and understand the patient's transference fantasies (transference fantasies to the therapist or others in the patient's life) in time for the patient to consider whether the suicide achieved what the patient imagined in fantasy. But as one analyst pointed out to me, even in the most intense and productive analysis, so much happens in a patient's life that goes unexplored and unknown to the analyst. And even when transference fantasies are understood and interpreted, they can still be acted upon by the patient. Thus it would be wrong to assume that in other treatments, fantasies are fully explored. As well, it would be wrong to assume that when transference fantasies are explored, the patient will not commit suicide. The hallmark of the treatments studied was not only lack of exploration

of the patient's suicidal fantasies. The defining feature of the treatments studied was that the process of exploration of the patient's fantasies, the process of analysis, had stopped. The analyst had given up hope in the analytic task and no longer believed that the patient's central difficulties could be addressed through deepening understanding of the patient's fantasies.

Yet, the dyad remained involved. The therapist seemed to believe that the relationship would be sustaining for the patient, usually through regular contact and a supportive approach. The therapist has the fantasy that the relationship is good and sustaining for the patient. If the patient sensed the therapist's hopelessness, what did it mean to the patient?

I suspect that what took place in this particular group of treatments is as follows. The patient was sustained for a long period of time by an unspoken fantasy of an ideal relationship with the therapist. At some point in these cases, the patient became aware that the patient did not have the therapist in the way the patient imagined. The therapist's separateness, the patient's lack of control over the therapist, the limits of the relationship and the non-ideal nature of the relationship came into the patient's awareness and the intense idealization flipped into an intense negative transference because of the meaning this had for the patient. Meanwhile, no process had developed for the patient to examine these feelings and the sustenance of the idealized relationship was gone. The idealized object was lost and analytic trust (Ellman, 1991) has not developed such that the patient can sustain hope through faith in the analytic process.

So again, what role does the treatment play in the suicide? Psychotherapy may be unable to delay a patient from enacting transference fantasies for long enough for the

patient to consider whether the suicide achieves what the patient imagines. Psychotherapy may be unable to stop a patient who wishes to enact the fantasy anyway. At most, psychotherapy can a) intensify an idealizing transference and b) increase the patient's fear of intolerable experiences and c) fail to create a place where the patient can experience the transference as fantasy d)fail to create a place where therapist can consider the therapist's own feelings as countertransference. Thus, the patient's wish for the ideal object is disappointed and it is not replaced by hope that the analytic process can offer the patient something else.

What role do the therapist's countertransference and the therapist's character play in the treatment?

In the cases studied, I felt there was a particular convergence of the countertransference elicited by the patient and the therapist's character proclivities. From the initial attraction, the "clicking" many therapists spoke of, there were signs of complementary and shared fantasies. The patient and therapist may have been good self-objects for one another, feeding each other's narcissistic needs. The therapists were unaware of the gratification of receiving the patient's idealizing transference and thus became more invested in maintaining the idealizing transference than in interpreting the defensive aspects of it. The maintenance of the idealizing transference is rationalized as maintaining a treatment alliance.

Further along in the treatments, it became clear the patients and therapists also shared feared, intolerable experiences. Often these were disavowed identifications. Jacobs (1998) has written about these kind of disavowed identifications that can be

projected by the dyad onto the patient's parents. Patient and therapist may then gratify disavowed sadistic fantasies by denigrating the parent figure together. It is possible that therapists may work to avoid being identified in the transference with the patient's bad objects, because the therapist cannot tolerate that particular identification. Specifically, it seemed that therapists longed to be identified with the ideal mother and avoided being identified with the bad, disappointing mother. Some therapists felt sadistic when putting appropriate limitations on the relationship. This may have contributed to the patients' confusion between limit setting and sadistic rejection.

I found that particularly true in clinic cases, where therapists were so anxious/guilty about inevitably abandoning their patients, that they were unable to tolerate the emergence of the transference portrayal of the therapist as abandoner.

Many theorists have suggested that the convergence between the characters of patient and therapist provides opportunity for productive analytic engagement. Racker (1957) wrote that therapist and patient, both being human were more than likely to overlap in the areas of conflict. Jacobs (1998) points out the therapeutic potential and the interpretive opportunity when the countertransference enactment is recognized. Ogden (1994) recognizes the potential that exists in such an intense involvement of the two subjectivities of patient and therapist.

The intense involvement, characteristic of the treatments studied, would not be seen as unusual or abnormal by Racker, Jacobs or Ogden. In fact, the intense involvement would be seen as carrying the potential for a successful analysis. The problem seems to be that the intense involvement was used to gratify the fantasies of patient and therapist and not used in the service of analyzing the patient. In my opinion, the question is not,

what is wrong with the therapist's character? Rather, I think we should ask, what prevented the dyad from using the intense involvement in the service of the analytic process?

When I presented this data to colleagues and supervisors, I met with a typical response. "Well, these are obviously very disturbed therapists. These are obviously extremely narcissistic therapists." At times, I myself wondered if that weren't true. However, I have come to believe that the therapists interviewed were well with normal range of character difficulties in the broader pool of therapists. I think the desire to pathologize the therapists is the kind of an enactment Jacobs describes, where we could idealize ourselves and project all kinds of bad character traits onto the therapists studied, and then gratify our sadism by attacking and denigrating the therapists' characters.

What about the patients' character may have put them at risk for suicide?

There are certainly many answers to this question. Books have been written about the character of people who commit suicide. But in the cases studied, there were noticeable similarities amongst the patients.

All had areas of very high functioning which gave the therapist rationale to be very hopeful early in the treatment about the patient's potential. More to the point, all of the patients were seductive and engaging in some way. They had a quality of being able to draw the therapist into an intense involvement and being able to perform as a narcissistic object for the therapist. They were experienced by the therapists as attractive, intelligent and engaging.

All of the patients had an intense idealizing transference to the therapist. The idealizing state was easily disrupted and needed to be constantly maintained and restored. Some patients showed agitation directed towards the therapist when the idealizing transference was disrupted but others experienced a generalized sense of disruption or sudden increase in symptoms when the idealization was disrupted. All of the patients had a quality of being easily and extremely disrupted. Thus, many of the patients had a clinging quality when they were trying very hard to maintain an undisrupted state. This vulnerability may have provoked the therapist to feel they needed to work to maintain the patient in an undisrupted state.

In many of the cases, it was apparent that separateness from the other had a particularly toxic meaning for the patient. Thus, extreme defenses were needed to deny separateness from the other and maintain an undisrupted, idealized state. The meaning of separateness to the patient cannot be known because these fantasies often went unexplored.

Why didn't supportive treatment work in these cases?

I found in the majority of cases that the therapist was working in a supportive mode at the time that the patient committed suicide. The therapist believed that this method would be helpful and sustaining to the patient. It is possible that the supportive method was unsuccessful because it was being used defensively to avoid the experience of the patient's negative transference.

I suspect that supportive treatment is successful when the patient can maintain a background idealizing transference fantasy that allows the patient to function in the

presence of a good object. Eventually, the patient perhaps moves into seeking gratification in other relationships.

In the cases studied, most of the patients showed improvement in areas of external functioning. But, the idealizing transferences were quite fragile and required constant maintenance for the patient to function well. The patients were too easily disrupted for the idealizing transference to perform a background, silent function. In addition, the meaning of separateness was so toxic to the patient, that any disruption was quite extreme. Perhaps, supportive treatment really became a frantic effort to maintain the idealized connection and there is little opportunity for the patient to use the idealized transference for further growth. The patients did not shift into finding more gratifying relationships outside of the therapy. If they did engage in relationships, they seemed to repeat a pattern of searching for a perfect object. Personal relationships remained volatile.

II. What Can Be Learned from this Study?

In this section, I will try to look at some of the theoretical questions that were evoked by this study and suggest areas for further investigation.

Dilemmas of the Idealizing Transference

Freud (1914) thought that the positive transference was unobjectionable. Kohut (1972) discovered that the idealizing transference may allow the patient to use the analyst as a self-object in the service of development.

Yet, this study suggests that the idealizing transference can facilitate and initial bond between therapist and patient, but can be problematic for the treatment in the long run. First and foremost, the idealizing transference is seductive to the therapist. At its most basic, it can feel very good to be on the receiving end of the patient's idealization. A colleague described the feeling she gets when she comes home from work each day to her 18 month-old daughter like this, "For two minutes a day, I feel like a rock star with a screaming fan running towards me" (Klein, 2001). She describes the kind of exquisite gratification of receiving the idealizing transference. Therapists who are working hard to connect to a difficult patient may feel they have earned such exquisite pleasure.

In the cases studied, the therapists often did not recognize the patient's positive feelings as idealization. They believed that the positive feelings from the patient were earned as a result of the therapist's ability to connect especially well to the patient. They told me with pride what they felt they had done to elicit such love from the patient. When the therapist is gratified by the idealizing transference, the therapist may be less likely to recognize the idealization and more likely to undermine the analytic task by working to maintain the idealizing transference. Therapists may do this by trying to be ideal objects to their patients. It is possible that this intensifies the patient's idealization of the therapist. The patient may feel encouraged to believe that the therapist is the ideal object and the patient may work harder and harder to cling to the therapist and the idealization.

The therapist may be less likely to recognize and bring to the patient's awareness the hostile edge of the idealizing transference. By this, I am referring to the times when the patient threatens, cajoles, or guilts the therapist into striving harder to maintain the patient in an undisrupted state. The hostile tinge of the idealization can be visible in some

of the mildest statements that reflect the patient's idealizing state. The patient says, "I couldn't wait to see you today." The therapist may not recognize the hostile edge of the patient's passion for the therapist. The patient is not only expressing longing, but perhaps a wishes to have more of the therapist, to control and possess the therapist and rage at the therapist's separateness. When the therapist does not recognize the hostile edge of the idealization, there is a missed opportunity for the therapeutic dyad to begin to experience and tolerate the patient's hostile feelings. Instead, an environment is created where the patient's hostile feelings are avoided. The patient's positive feelings do not grow out of a new experience of being understood and an experience of having negative feelings tolerated. The patient's positive feelings are maintained through a subtle seductive promise that the therapist is the idealized object and that disrupted states can be avoided.

But, how can the therapist's handling of the idealizing transference make matters worse? I believe that in these cases, the patients came to treatment with the belief that they needed to maintain themselves in an undisrupted state (with the idealized object) and that certain intolerable experiences had to be avoided or the disruption would be tantamount to death.

The patient comes to therapy with certain beliefs that are really questions. I need you to maintain me in an undisrupted state, don't I? This feeling is a horrible, intolerable experience, isn't it? The therapist's stance may imply answers to these questions. For example, when the therapist cannot tolerate the patient's negative transference, the therapist is confirming the patient's subjective experience that certain feelings must be avoided to preserve the relationship. This can be experienced as a repetition of the original traumatic relationship with the parent.

The therapist's stance towards the patient's desire to maintain an undisrupted state is critical to how the patient experiences disruptions. If the therapists acts as if the patient's desire to maintain an ideal, undisrupted state is a wish, then the therapist can accommodate the wish at times without undermining the analytic task. For example, a therapist might delay an interpretation or give an extra session with the full intention of continuing to analyze what the patient wants from the extra session. In this case, the therapist has in mind the impossibility of the patient's wish and the inevitable disappointment of the patient's wish. The therapist hopes that patient and therapist can experience the patient's disappointment, tolerate the patient's negative feelings, understand the particular meanings the disappointment has for the patient and deepen the relationship. The therapist is empathic to the patient's suffering, but is mindful of being separate and unable to omnipotently take away the patient's suffering.

But if the therapist treats the patient's desire to maintain an undisrupted state as an absolute need, then the therapist is liable to make all kinds of accommodations without analyzing the accompanying fantasies. The therapist is likely to feel guilty when the patient feels disrupted and the patient is likely to feel they have too much control over the treatment. The therapist may act too omnipotent as if the therapist could prevent the patient from experiencing disruption and upheaval. This may confirm the patient's fantasy that therapist and patient are not really separate.

Broader Theoretical Implications:

The data of this study can be used to consider important theoretical and technical questions in psychoanalysis, particularly about the idealizing transference.

Different schools of analysis have argued about whether and when to interpret and idealizing transference. The data of this study suggests that there is an important distinction between allowing an idealizing transference and encouraging an idealizing transference. In the cases studied, the therapists encouraged the idealizing transference. More importantly, the therapists did not recognize the patients' positive feelings as an idealizing transference and therefore did not recognize the defensive aspects of that idealization. The following questions are evoked by this study. What are the dangers of encouraging an idealizing transference? When does the idealizing transference serve the function of gratifying the therapist's and the patient's wishes and when does the idealizing transference serve the function of furthering the patient's growth and development? Why is the idealizing transference difficult for the therapist to recognize? And what are the dangers when the idealizing transference goes unrecognized?

The Difference between the Creation of a Good Relationship and the Creation of an Analytic Involvement where Analytic Trust (Ellman, 1991) Can Develop:

In this study, all of the patients and therapist were emotionally involved in the therapeutic relationship. All of the therapists reported a good relationship with the patient. I suspect many of the patients would have reported a good relationship with the therapist. One implication of this study is that there is a difference between creating a good relationship with the patient and creating a relationship where the patient can explore all manner of both positive and negative transference states.

The difference can be seen when the patient is disrupted. The therapist may intervene to repair the disruption in the relationship by insisting that the patient see the

therapist as a new object. But in these cases, that stance may have served the function of solidifying the idealizing transference. When the therapist intervenes to create an analytic involvement, the therapist tries to understand why the patient was disrupted and how the disruption feels to the patient. There is no rush to repair the disruption and no communication to the patient that the therapist needs the patient to be in an idealizing mode. The therapist may welcome the disruption as an opportunity to further explore the patient's experience. Thereby the therapist is being a new object by listening to the patient's experience of the disruption and tolerating the patient's expression of distress.

In terms of empathy, I would argue that in the cases studied, the therapists believed that they were being empathic when in fact they were trying to maintain the patient an undisrupted state. This is a misunderstanding of empathy. The therapists were trying to be the patient's ideal object rather than understand the patient's wish for an ideal object. An empathic response to the patient's wish for an ideal object does not require the therapist to try frantically to maintain the patient in an undisrupted state. Rather, the therapist can be empathic by listening to the patient's sensitivity to disruption, helping the patient to recognize those sensitivities and helping the patient to recognize the wish for an ideal other. It is particularly important that the therapist recognize the hostility in the patient's wish for an ideal other, so that the patient senses that the therapist is empathic to the patient's hostility without feeling pressured to erase the patient's distress. Empathy, in this sense, demonstrates that the therapist can tolerate the patient's states of distress without acting as if the therapist can omnipotently prevent the patient's distress. In this way, empathy is the precursor to containment, as the therapist demonstrates that the therapist can experience and tolerate the patient's negative affect.

The Problem of the Therapist's Idealization of the Self as Therapist and the Therapists' Difficulty Identifying with the Patient's Bad Objects:

It is a common presumption that therapists become therapists out of a wish to repair their objects. In the cases studied, I was struck by how important it was to therapists to feel that they are a good, reparative presence in their patient's lives, not only in the long run, but in every interaction with the patient. Therapists often liked to see themselves as kind, generous, and even selfless in the role as therapist. I found that the therapist's idealization of self interfered with the therapist's ability to create an analytic involvement.

Therapists were unable to set and maintain the limitations of the treatment relationship. The therapists were unable to maintain a positive sense of self when setting an appropriate limit. Thus, when therapists broke the frame of the treatment, they believed that they were doing it in the best interest of the patient, but it may have been done to preserve the therapist's sense of self as a good reparative presence.

Several therapists told me that they did not feel guilty about the patient's suicide because they felt that they had been "available" to the patient. It seems to me that therapists had an extraordinarily difficult time tolerating identifying with and being identified with the patient's bad objects. Even at a most basic level, therapists were unwilling to identify with and be identified with the unavailable parents who limits the gratification of the child because the parent believes it is in the child's best interest.

As I will discuss in the following section, I believe therapists had a particularly difficult time because they did not have a faith in the analytic process to rely on to help the therapist maintain a positive sense of self.

The Importance of Faith in the Analytic Method:

This study suggests the importance and the difficulty of creating an analytic involvement. I would propose that the treatments studied often got derailed when the therapist's faith in the analytic method was threatened.

The analytic method provides the therapist an understanding of the importance of the limitations of the relationship for the patient's growth. Both therapist and patient's wishes are frustrated in the treatment relationship. The therapist will only feel comfortable frustrating himself and his patient if the therapist firmly believes in the utility of frustration in the analytic process. Without this understanding of the analytic method, the therapist is likely to feel cruel, depriving and sadistic when maintaining the limits of the analytic involvement. The therapist needs faith in the analytic method to sustain the therapist's positive sense of self. It is not unlike one parent looking to the other parent for an encouraging nod when the parent must say no to the child. Faith in the analytic method can perform the function of the other parent in the treatment (Solow, 2001).

Faith in the analytic method is also critical in the therapist's willingness to allow the patient to experience any feeling in the treatment relationship. As suggested by Maroda's (1999) conceptualization of surrender, the therapist can really only surrender to a full experience of the relationship with the patient when the therapist really believes in

the analytic method. In the cases studied, therapists seemed to lose faith in the analytic method when the patient brought intolerable experiences and feelings to the relationship. Suddenly, certain experiences and feelings are avoided by the therapist and the treatment relationship serves the function of helping the patient to better defend against the experience of those feelings.

One rather obvious hypothesis, for which I have no particular evidence, is that the therapist will only feel faith in the analytic method when the therapist has felt that they experienced the usefulness of the limitations of the analytic involvement in their own treatment. If they continue to experience the limitations of their own treatment as solely oppressive then they will be unlikely to have the ability to maintain a positive sense of self when placing limitations with their patients. In addition, the therapist must feel that his or her own intolerable experiences were experienced in the treatment and believe that this was beneficial to the therapist finding more freedom in the therapist's life.

Conclusion:

In this discussion, I tried to answer tentatively some of the most difficult questions this study approached. I hope by this point I have made indelibly clear that my discussion of these questions is based on my subjective interpretation of the cases. It also based on the particular cases that were studied. Presumably, these cases are a particular subset of all cases of suicide in psychotherapy.

In this discussion, I have gone beyond the themes and particular cases, to summarize and discuss some of the theoretical and technical questions that were evoked by the data. The problems of the idealizing transference, the creation of an analytic

involvement and the importance of the therapist's faith in the analytic method are examined.

CHAPTER SEVEN

CONCLUSION

The purpose of this study was to examine cases of patient suicide in psychotherapy. Although suicide has been discussed from many perspectives in the literature, there is little documentation and case study material of cases of suicide in psychotherapy. Clinical matters have often been studied through a case study method. Case studies of treatment are usually done through the therapist's account of the treatment.

In this study, cases were examined through in-depth interviews of the therapist. The therapists were asked to recollect their experiences with the patient and to talk about what they felt they learned from the experience of treating the patient and from the patient's suicide. The therapists revealed the intense drama of the involvement between therapist and patient. Therapists spoke at length about their intense feelings about their patients, the treatment and the patient's suicide. The interviews had elements of a case consultation and a brief psychotherapeutic intervention, but the interviews were meant primarily to try to gain a better understanding of the therapist's experience of the treatment.

The interviews had a kind of intimacy that is quite rare in the field of research. I feel that in this study, the therapists and I entered into the strange netherworld where feelings about patients reside. The therapists had not talked about these feelings in their personal lives, nor really in their professional roles. Even those therapists who were in analysis subsequent to the suicide did not feel they had ever really taken the opportunity

to explore their feelings about the case discussed. One might assume that in cases of suicide, the therapists are silent out of shame. There may be some truth to that. Certainly, it may explain why so few therapists write up cases of suicide. But I think in general, there is very little discussion of failed cases. Perhaps, a supervision or a consultation takes place. But how often do therapists really explore the netherworld of their feelings about patients when the patient leaves treatment prematurely? I suspect that therapists are more likely to talk about cases of suicide because the emotions of guilt, shame and grief are so strong and because the real death of the patient may allow the therapist to feel more comfortable with the intensity of his or her feelings.

One therapist described to me how she stored the files of terminated cases. She turned certain patient files backward so that she wouldn't have to see the names on the file tabs. Just the sight of certain names evoked so many painful feelings. The patient who suicided was one of these backward files, but so were many other patients where the therapist felt uncomfortable with the way the treatment had ended. The file of terminated cases reminded me of a graveyard full of headstones. Some headstones filled the therapist with positive feelings and other headstones filled the therapist with anxiety over ambivalent feelings. Where does each therapist keep his or her graveyard? How do we feel when we look at the headstones? Have we really put in the time to understand the complexity of those feelings? How much does our work suffer when we don't look at those feelings? And how much do we suffer as people when those feelings can't be tolerated?

In this study, I asked therapists to take a hard look at the headstone of the suicided patient and talk about the experience. I think the therapists really opened themselves up

to the task. I have spent a lot of time worrying about how the therapists will feel about my understanding of their cases.

In a sense, the process of this study is like psychoanalysis. I didn't really know what I would find when I opened the doors I opened. The things I discovered along the way were neither pleasant nor easy to digest. And yet, there has been something enlivening and freeing in facing some of the painful questions in this study. I think that therapists have found it so immensely painful to look at therapeutic failures, including cases of suicide. As a result, as a field, we have really missed an opportunity to learn much more about our work and the opportunity to come to terms with our own limitations.

APPENDIX A

Interview Protocol
Therapists' Experiences of Patient Suicide
PI: Hilary Rubenstein

Part A:

Therapist Data:
Age_____
Degree _____
Level of Training_____
Type of Practice _____
Theoretical Orientation _____
Specialization/ Particular Interests _____
Timing of Suicide in Therapist's Career _____
Time Elapsed since Suicide_____
Experience in working with Suicidal Patients _____

Patient Data:
Age_____
Occupation_____

Can you orient me to your work with this pt?
When did you start work? How long did you work together? What was the frequency? Was the work continuous? Were there other clinicians involved (psychiatrist, couples therapist)? What was the patient's fee? How was the patient referred to you?

Part B:

At this point in the interview, the subject is asked:
Would you describe the patient and tell me what happened in the treatment?

Part C:

The therapist is asked any of the following questions that were not answered spontaneously in their description of the case.

1. Diagnosis and Prognosis:
Did the patient have a history of suicide attempts, psychosis, major depression, violent behavior, physical or sexual abuse?

Was there a history of suicide in the patient's family?

What was the patient's life like during treatment –job, living situation, martial status, etc.

Was the pt ever in treatment before?

Did suicidality come up in the initial phase of treatment? If not, how did the patient articulate their presenting problems?

What was your formulation of the source of the patient's difficulties?

Prior to the suicide, were you optimistic about the treatment?

Did the pt express wishes for a relationship with you outside of the therapeutic relationship? How were those wishes disappointed? How did the patient react to this disappointment?

2. The Final Phase of Treatment:

Now I'd like to ask more about the time just prior to the suicide. Can you tell me what was going on at that time?

Did pt communicate suicidal thoughts?

Did suicide come up in your mind?

Does anything about the last few sessions stand out for you?

Did anything change in the frame of the treatment prior to the suicide? (Did the suicide relate to a separation from you?)

Were there particular events that took place in pt's life just prior to suicide?

Was there anything in the patient's dreams that in retrospect may have communicated suicidal intentions or thoughts?

3. The Suicide:

Can you tell me more about the specifics of the suicide?

Was there a suicide note?

What did you find out after the suicide? Were there secrets kept from you? Prior to the suicide, did the patient keep secrets from you?

Did the patient pay their bill before the suicide? If not, was it ever paid?

How did you find out about the suicide?

How surprised were you?

4. The Therapist's Understanding of the Suicide

What do you think happened? Or What is your hypothesis about the patient's suicide? Why and why at that moment? (has a sense of the patient's state depressed/ manic/ psychotic been elicited?)

Are there things that you feel you missed (aspects of the pt's personality, suicidal communications, impact of life events)?

Besides the suicide, was there anything that stands out in your mind as unique about your work this pt?

5. The Impact of the Suicide

Now I'd like to ask you more about the impact of the suicide on you:

What were the weeks after the suicide like for you? (Intended to elicit emotional state and events that took place, funeral, autopsy, consultation, etc.)

Has the suicide affect you in a longer term way? Has the suicide affected your work? Has it changed you as a therapist? (changes in theory? in practice? in patient population?)

What, if anything, do you feel you learned from this experience?

Do you ever think of the patient? What do you think about? Do you ever dream about the pt? How do you feel about the pt. now? Do certain pts. remind you of the pt. now?

Are there things you wish you had done differently? Or knowing what you know now, would you handle the treatment differently?

Part D: Debriefing the Interview Process:

Is there anything more that you would like me to know that we haven't talked about?

How have you felt revisiting the suicide now?

APPENDIX B:

Informed Consent Form

The purpose of this study is to explore therapists' experiences of patient suicide. I am particularly interested in hearing what therapists feel they learned from this experience and how the experience has impacted their work.

Therapists who have had a patient suicide while in treatment are being asked to participate. I plan to meet with each subject for at least two tape-recorded interviews, each lasting approximately one hour.

To Participants:
I appreciate and respect your willingness to participate in this research project. Given the sensitive nature of the topic, I am aware that during the interview process difficult feelings may emerge. Please understand that you are free to refuse to discuss anything which causes you discomfort. At any time during or after the interviews, I will be available to meet with you to discuss any concerns you have as a result of this reflective process.

All research data will be kept strictly confidential. In the event of publication or presentation, all identifying information will be changed and pseudonyms will be used. You have the option to approve all written material pertaining specifically to you to ensure that it meets your standard of confidentiality.

Please sign below to indicate your understanding and willingness to participate in this research project.

Thank you.

Hilary Rubenstein
Doctoral Candidate
Clinical Psychology
City College, CUNY

To Be Completed By Participant:

I have read the above statement and understand both the purpose and procedures to be used in this study. I agree to participate in this study as described. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Signature_____

Address and Phone Number:

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