To Be or Not to Be:
Walking on the Edge of Life and Death with a Suicidal Patient

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This paper is a kind of coming out experience. I am coming out of the closet of silence regarding one of the most difficult prospects we clinicians face: the suicide of a patient. It is a possibility we all dread, bringing with it a host of anxieties--doubts about our clinical competence, fear of legal liability, and shame about the possible negative judgment of our peers. All these can create a deep closet. But I choose to come out of this closet in the hopes that it will benefit both you and me. After I had submitted my proposal I began to have second thoughts. I anxiously reached out to some trusted colleagues in IFPE who encouraged me to persevere, believing that IFPE is the kind of community of learning where it is safe to share something so charged and vulnerable.

My paper falls into two parts: First some clinical material and some general questions I will pose.

"To Die, to Sleep"

I heard a strange sound coming from my waiting room. It was a low tone that slowly began to rise in pitch and volume. I had never heard anything like it. It was eerie and disconcerting. Slowly I began to recognize a human voice saying one word over and over: "Please, please!" I opened the door and there was Michael pacing back and forth frantically, holding his head in his hands. He was moaning in pain like a trapped animal. As he came into my office he remained standing and said in a sobbing voice, "Phillip, I wish you had a gun and could shoot me!" That was our last session after fourteen years together. He had been referred by his parish priest who was concerned about Michael's suicidal urges. He was a very thin, nervous 50 year old man whose neat, simple shirt and suit hung on him like a scarecrow. In our first session I got the short version of Michael's mental health treatment: five years in five times a week classical analysis that he said had given him insights but in his words "did not fix my problems" and then a brief time in Cognitive Therapy which he described as "almost worthless". When I asked about medication he described a list that was a virtual history of psychotropics from the early sixties on forward. Some had helped soften his depression and anxiety a bit but
then invariably brought side-effects and were discontinued. He had a medical history full of maladies--gastric, intestinal, vocal problems, neuropathy in hands and feet. None of these was life-threatening and they each eventually subsided just as mysteriously as they had developed, sometimes to return later as the focus of more anxious obsessing.

Michael—as I will call him-- held a position of great responsibility in his profession. His work was his life. He would work long hours each day and through the weekend. He had little social life. He had three supportive siblings who were all married and apparently by his descriptions were doing better than he was psychologically. He was close to one sister but felt distance from the others. He was the oldest but also, as he said the "oddest". He was painfully aware that his siblings had all married and had children while he had not. This provoked envy and shame in him. In terms of relationships outside the family, he had been attracted to several women over the years but these relationships were never consummated physically or emotionally.

His primary human interaction outside work was his church where he held key positions. Lest I portray him only in terms of his unhappiness, there were some alive parts of his life—at least in some limited ways and for a time. He had excelled at baseball as a teenager—he had been an excellent pitcher but he eventual froze up and could not pitch well. He told me that sometime in the past he had taken ballroom dancing lessons which he enjoyed for a while then it ended—for reasons I cannot remember. He became a member and eventually the president of a public speaking club because he wanted to challenge his fear of public speaking and he worked to find his own voice. That seemed to be a good experience. All these seemed like glimpses of what Winnicott called True Self aliveness—a primary spontaneous gesture always rooted in the body. But they were but glimpses of aliveness and did not overcome his constriction.

As I reviewed his file in preparation for this paper, I thought of diagnoses—how many could be applied to Michael--Obsessive Compulsive Disorder, Anxiety Disorder, Somatization Disorder. From his psychoanalysis Michael had also been given the diagnosis of Castration Anxiety. There was also an Asperger's quality to Michael, a lack of social cuing that had an autistic feel. "Diagnosis" comes from the Greek meaning "to see into, to come to know". At its best, diagnosis is not a way of pigeon-holing someone but an ongoing attempt to know someone better: Who is this unique person and how can I know and help them? I think that is what I felt as I first sat with Michael. Looking back on his previous history it might seem like the height of foolishness, naïveté, or therapeutic grandiosity to take him on as a patient but from the moment I met him there was something about him I liked and respected. He was bright, thoughtful, and a person of utmost integrity. And he really did want to have a better life. So we embarked on our years together. As I look through my notes I can see all the ways I tried to help him:
interpretations, affirmations, exploration of the transference. There was lots of rich material: his strong supportive father who gave endless advice but at the price of demanding Michael surrender his autonomy. This became a frequent theme in our early work: his seeking my support and advice but also feeling resentful and impinged upon if I gave it. He was also concerned about taking care of me saying, "I am afraid that if I don't get better you will feel you failed as a therapist". At the time I heard that comment through the lens of his tangled relationship with his father which was filled with competition, aggression, and devaluation. But now I can take it as an early message from Michael about the eventual state of things and a kind of absolution. It would be the only suicide note he would leave me.

Through our years together Michael had periodic times of feeling suicidal although, to my knowledge, there were no actual attempts. I did the usual things: make a suicide contract, ask him to call me if he was moving toward action. Most of the time the topic of suicide receded in the continual stream of everyday struggles. When I explored the topic more pointedly he said he could not do it because of the impact it would have on others. But even if he could not bring himself to commit suicide he sometimes expressed a desire to no longer exist, to be relieved of the intolerable weight of being. One day he brought in a prayer by the French priest Michel Quoist entitled "Nothing, I am Nothing…"

"I see the devil attacking the key points of the fortress
that I thought impregnable, and I find myself tottering and ready to fall.
I see my helplessness--
I who thought I could make myself of value to you...
Nothing, I am nothing;
I accomplish nothing. I know it now...
I am nothing
And you are all".

The prayer was intended as an expression of a piety of radical humility and total submission to God. Although he felt the prayer described his desolation he was most drawn to the words "I am nothing" and felt them to be comforting. To be nothing, nothing. This was the lure of non-being, to die, to sleep, to shuffle off his mortal coil. For Michael it was a consummation devoutly to be wished.
There were many twists and turns as there are bound to be in such a long treatment. I can see the hand of different supervisors in my notes—the differing emphases of my various training and readings. But Michael was my best supervisor as our patients always are. They teach us—if we can listen—to what they need and not just what we want to give them. He told me that what was most helpful was for me simply to be with him, to listen. He felt less alone. He could, in Winnicott's terms “be alone in the presence of another”. He often wished he could stay in my office. "You are my anchor, my best friend, the only one I can talk to" he would tell me from time to time. I had forgotten those comments until I reread my notes. They helped me feel the meaningfulness of our work together despite its dark ending.

Michael constantly complained about work. He hated the public exposure it required, his feeling of incompetence in supervising others, the compulsivity that kept him checking and rechecking his work. But although his job was burdensome it provided a container, something to lose himself in, a reason to put off having more of a life, a distraction—albeit a not always successful distraction—from the frightening demons of hopelessness, panic, self-hatred, rage, emptiness and inconsolable despair. He obsessed years about when and if to retire. Finally at 64 he left his job of almost thirty years. Although all the signs of danger were there, I hoped that freedom from the pressure of work might give him some relief. At first that seemed to be the case. He was still able to work as a part-time consultant at his old job and was grateful that he felt less pressure. He volunteered at some non-profits that he supported. It seemed obvious that many people valued him. But after a few months of semi-retirement the demons began to descend. Michael became more panicky. He was a man without a shell—without a psychic skin—feeling completely exposed both from the outside and from within. His psychiatrist and I had been working in close consultation and decided to admit him inpatient—a prospect that Michael was very attracted to. He imagined it as a place of refuge, a sanctuary of care where he could regress to a state of dependency and escape the pressure of the outer world. But I knew that in this age of managed care this would not be possible. The psychiatric ward of the hospital simply upped his meds, kept him from self-harm then released him after a few days. He was back on the street, sentenced to life.

The last session where he had moaned in the waiting room and paced and sobbed in my consulting room, I felt a major shift in me; an acceptance of what could and could not be. I no longer tried to encourage him, give him hope. I let myself simply sit with him in his despair. I called upon an episode of depression in my life which taught me that no one can really know what it is to be depressed unless you have experienced it yourself. I relinquished my role as holder of hope and sat with him in the hopelessness. I said "The pain must be horrible. No one can fully understand, even me. People try to encourage you but it would be such a relief not to suffer anymore". I was not fighting the
despair. I entered it and as I did, I felt a profound acceptance and relief. At the end of
the session he said, "I felt like you have really gotten me today. You feel the most
attuned to me I have ever felt. It feels like a comfort and validation." Together we were
both accepting what could and could not be. For Michael “the heartache and the
thousand natural shocks that mortal flesh is heir to” had become intolerable and “to die,
to sleep, perchance to dream” was a stronger desire than living. Unlike Hamlet who
pulled back from non-being for fear of hell, Michael chose non-being to escape hell.

A few days later Michael hung himself in his apartment. He left no note. His desire to
end the pain had overcome his concern about the effect on those left behind. With his
usual fastidiousness he left all his affairs in perfect order. When I heard the news I felt a
sense of profound solemnity, some sadness and some relief. I wasn't sure he had the
resolve to do it but he finally did. I felt no guilt. Everything had been tried. The race had
been run, the struggle was over. We were both off the tightrope. At his funeral many
people spoke movingly about he had touched their lives. People from work spoke of
what a patient and kind man he was, what a good mentor to others. People from his
church talked about is selfless service and compassionate ability to listen. These
remarks felt very genuine—not the avoidant fictions often voiced in funerals. It was as if
I were listening to the description of some other life. The Eriksonian middle to final life
poles of generativity or despair were split. Others had felt his generativity but he could
not take in how much he had touched others. What he was left with was the despair.

I was privileged to have walked with Michael for fourteen years. In is now almost five
years since he died. From time to time I miss him and I sometimes look at the chair
where he sat and I imagine him there. I can see his thin body, see his face and hear his
voice. I have needed to join my voice as well. When I am not wearing my clinical hat I
enjoy my avocation as a singer-songwriter. Soon after Michael died I wrote these song
lyrics. I have not set them to music and don't know if I ever will. Perhaps this is the one
time they will find voice beyond my private thoughts:

“I got the call this morning;
They found you in your room.
They found you left there hanging
From your rope of dreadful doom.
Did you think for an awful moment
That you’d made a grave mistake
Or was it only blessed peace
And release from the awful weight?

So many years I sat with you
But I could not lift your load.
Your path grew dark and narrow
At the end of a long hard road.
When I said "No one can understand"
You said I finally understood.
You were driven by your demons
Into a dark and desperate wood.

I’m grateful that I walked with you
And I think I did some good.
I know you fought the valiant fight
And you did the best you could.
In the middle of my sorrow
I have not lost the hope
That love was there to catch.
At the end of your rope”.

2. REFLECTIONS

I want to pose some questions for reflection:

1. Is healing the same as cure?

To answer this question we must think about our fundamental understanding of the analytic process. Is it cure? If so, cure of what? What can be cured? How do we discern the difference between conflict and deficit? Both can exist. Michael had internal conflicts that had arisen from early relationships. There was a lot of Oedipal material and it seemed clear that his conflict with his father had never been resolved. This affected his confidence in his own autonomy and initiative. We were able to free him up a bit in this area so that he was better able to relate at work and with his family. But the deficits were profound. I think some of them were probably physiological. He had an anxious, and inconsolable temperament that was evident in his first days. His mother had told him that as infant he had cried almost constantly, and was hard to hold--I could relate to that. I thought of Winnicott's "primitive anxieties", one of which is being dropped and falling forever. We have all had these feeling but they are stronger and more enduring for some of us.

Freud did not believe in complete psychic determination. In Analysis Terminable and Interminable” he spoke of a "complimentary series" in which physical temperament was
an inescapable factor. He was enough of a neurologist to know that you can't ignore the nervous system as a vital factor in personality. He wrote:

“The aetiology of all neuroses is a mixed one.. generally there is a combination of two factors: the constitutional and the accidental. The stronger the constitutional factor the more readily will trauma lead to fixation”

Michael would sometimes exclaim, "It's not fair! Life is so much easier for most other people!" He was right. If these deficits could never completely be filled was there any benefit in my treatment of Michael? Was all our work in vain, a mere building and rebuilding of a flimsy dam against the unstoppable torrents of despair? If we shift from a one-person model of psychoanalysis to a more relational model then the relationship itself is the vehicle of healing, not just the one-sided interpretations of the omniscient analyst. Despite deficits there can be something healing about being in a long-term relationship even when that relationship is asymmetrical. Michael once said, “I know this is a professional relationship but it is very precious to me. I need to talk. Thank you.” Although this might not be a cure of his deficits, his experience and mine of being in relationship brought some healing of isolation. Not a perfect healing for we all carry wounds throughout our lives—but a healing that comes when our wounds become channels of connection. Then we know we are not alone. We get us a glimpse of a deeper permanence in which we are all imbedded—a cosmic life-force from which we come and to which we go—a force which most world religions call love.

2. Is there a resistance to impermanence and limitations of our clinical work?

We all want our patients to get better. It makes us feel better. We have more sense of agency and satisfaction and in some way we continue our own healing by helping another become more whole. But our therapeutic zeal can sometimes be driven by our narcissistic defenses against feeling a failure, feeling controlled by the patient, being shamed, judged as incompetent, even uncaring. Certainly there are many cases of suicide that can be prevented. A man in his twenties whom I see was functioning well in his personal life and at work until a profound depression laid him low. He began for the first time to contemplate suicide. There was a history of depression in his family. He responded dramatically to antidepressants and is now functioning well again. This is a very different case from years of emptiness and psychic pain. When things don't seem to improve or improve as much as we hope, we are faced with the transience of our work in an unsettling way.
3. Can our strong urge to keep patients alive overlook their autonomy?

Although we can never keep someone from taking their own life we may neglect the fact that suicide can sometimes be an act of existential autonomy. Obviously this is often not the case when depression is untreated in an otherwise fairly well-functioning person. We know that suicide can often be a cry for help; a hope of intervention and care. It can be an expression of anger that may be worked through at least to some degree in the therapeutic relationship. But the question of whether to be or not to be always ultimately always lies in the hands of the patient and all our best intentions cannot take away their freedom. We may try, unwittingly, to use our therapeutic role to control the patient to make the choice we want them to make. Our attempts to make everything turn out alright can be a manic defensive against facing the limits of our power. The right to die is hotly debated in medical terms, but what of psychic pain? If mental suffering is intolerable, do we have the right to cancel out the other's power to choose life or death?

4. Can our insistence on the patient continuing to live be a resistance to facing our own death?

No analysis is interminable. The analysts and the patient must both die. Everything ends. Like the sand mandala being built here, all our best efforts as healers—although not unimportant—must all be blown away as we and our patients will be. Nothing lasts forever. Sometimes our therapist zeal is a resistance to this inescapable and unsettling fact. As I look back on my work with Michael I realize that my own feelings about being alive colored the way I saw his struggle. I have not yet achieved a peaceful acceptance of death. I want to cling to life as long and hard as I can. But I came a little closer to an acceptance of my own limitations as I journeyed with Michael; I stopped pushing to avoid the death of hope and paradoxically space was made for a more reasonable hope—a hope of companionship, of conversation, the sharing of a life story. A life story is never meaningless, not matter how full of pain it may be. But the story does not go on forever and knowing this can make it more precious in the present moment. The winds of time may blow us all away like sand but oh the colors and the patterns we sometimes see—even when we see them through tears!
REFERENCES


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