In his chapter 'The role of the father in a pre-suicide state' Donald Campbell also stresses the use of attacks on the body to get rid of a painful mental state. For suicidal patients 'it is the body that is treated as an object and concretely identified with the lost and hated person'. Although there are different phantasies related to suicide, Campbell suggests that each is underlined by a wish for the 'surviving self' to 'merge with an idealised maternal imago', that is, suicide is intended to kill the bad, annihilating mother and to permit fusion with the ideal mother. The particular patient Campbell discusses had throughout his life felt let down and neglected by his father, abandoned to a sado-masochistic relationship with his mother. In the analysis he convinced his analyst that he was improving, inducing the analyst to be less vigilant about suicide than usual and hence to become 'neglectful' as the patient thought his father had been; the patient then absented himself from sessions and made a serious suicide attempt. The dynamic of the suicide attempt was later understood and worked through in the analysis.

This paper may be inserted in the line of papers discussed in the review of the literature which point out to the relevance of the role of the father in enabling a child to separate from his mother. Although the patient's suicide fantasies were based on a pathological bond with his mother, during the pre-suicide state the internalised father who had failed to protect his son from the father was evoked in the counter-transference to function as a sanction for the suicidal act.
The role of the father in a pre-suicide state

DONALD CAMPBELL

The pre-suicide state and the suicide fantasy

In 1910 the Vienna Psychoanalytic Society held a symposium 'On Suicide': with particular reference to suicide amongst young students. Wilhelm Stekel's contribution identified revenge as a motivating factor in the suicide act:

The child now wants to rob his parents of their greatest, most treasured possession: his own life. The child knows that he will thereby inflict the greatest pain. Thus the punishment the child imposes upon himself is simultaneously the punishment he imposes on the instigator of his sufferings'.

(Stekel, 1967, p. 89)

Freud explored aggression turned against the self in suicide further in his paper 'Mourning and melancholia' (1917). Freud observed that in melancholia, after a loss or a 'real slight or disappointment' coming from a person for whom there are strong ambivalent feelings, the hate originally felt toward the person may be redirected toward a part of the self now identified with the person. Instead of letting go of the person there is a regression to identification and sadism influenced by the ambivalence toward the person. Freud took this observation further:

It is this sadism alone that solves the riddle of the tendency to suicide which makes melancholia so interesting — and so dangerous. ... The analysis of melancholia now shows that the ego can kill itself only if ... it can treat itself as an object — if it is able to direct against itself the hostility which represents the ego's original reaction to objects in the external world.

(Freud, 1917, p. 252)
In the suicidal individuals I have analysed it is the body that is treated as an object and concretely identified with the lost loved and hated person. My understanding of suicidal patients is influenced by Freud’s observations and begins with the view that in these patients a split in the ego has resulted in a critical and punitive superego perceiving the body as a separate, bad or dangerous object.

Whatever else is said about suicide, it functions as a solution born of despair and desperation. An individual enters a pre-suicide state whenever the normal self-preservation instinct is overcome and their body becomes expendable. In some cases, the patient’s rejection of his or her body comes silently, or may appear only indirectly in the material - about which I will say more later - but once this has occurred a suicide attempt may be made at any time.

During a pre-suicide state the patient is influenced, in varying degrees, by a suicide fantasy, based on the self’s relation to its body and primary objects. The fantasy may or may not become conscious, but at the time of execution it has distorted reality and has the power of a delusional conviction. The suicide fantasy is the motive force. A person’s promise or conscious resolve not to kill themselves, or even a strong feeling that suicide is no longer an option, does not put them beyond the risk of another attempt on their life. As long as the suicide fantasy is not understood and worked through, the individual is in danger of resorting to suicide as a means of dealing with conflict, pain and anxiety.

I have paid particular attention to suicidal patients’ fantasies about death and their affects and thoughts during the build-up to a suicide attempt in which they clearly intended to kill themselves. Their attitude towards death by suicide and their suicide fantasies confirm Maltzberger and Buie’s (1980) observations of suicidal patients and their formulations. While each patient expected his or her body to die, they also imagined another part of them would continue to live in a conscious body-less state, otherwise unaffected by the death of their body. Although killing the body was a conscious aim, it was also a means to an end. The end was the pleasurable survival of an essential part of the self, which I will refer to as the ‘surviving self’, a self that will survive in another dimension. This survival was dependent upon the destruction of the body (Maltzberger and Buie, 1980).

Merging with mother and annihilation anxiety

From the analysis of my suicidal patients it was possible to form a general picture of an object, which, in Freud’s terms, was now identified with the body, in order to understand why the body became expendable.

In each case the narrative point of origin of the psychopathology (Stern, 1985) was built around a mothering object which was perceived as dangerous and untrustworthy. Separation and individuation had proved too painful for these patients and they withdrew cathectic from others while maintaining a fantasy of a regressive move to merge with an idealised mother who would meet all their needs. However, these patients felt themselves to be in a double bind. While being preoccupied with this wish to merge with mother, they become anxious about being engulfed by the object if they should succeed in merging, or being abandoned to starve if they should be unsuccessful in getting into the object (Glasser, 1979).

Although there were different types of suicide fantasies (see Maltzberger and Buie, 1980; Campbell and Hale 1991) each fantasy was underpinned by a wish for the ‘surviving self’ to merge with an idealised maternal image. The suicide fantasy represented a solution to the conflict which results from the wish to merge with mother, on the one hand, and the consequent primitive anxieties about annihilation of the self, on the other. By projecting the hated, engulfing or abandoning primal mother on to the body and then killing it, the surviving self is free to fuse with the split-off idealised, desexualised, omnipotently gratifying mother represented by states of oceanic bliss, dreamless eternal sleep, a permanent sense of peace, becoming one with the universe or achieving a state of nothingness (Maltzberger and Buie, 1980).

Just as there was a split between the good ‘surviving self’ and the bad body, there was also a split between the hated, engulfing or abandoning primal mother, now identified with the body, and the idealised one with which the ‘surviving self’ would safely fuse once the bad mother/body had been eliminated.

The case of Mr Adams

Mr Adams was a ‘mummy’s boy’, who was alternately indulged and abandoned according to the whims of his narcissistic mother. He felt rejected by his father who was seldom at home and appeared to favour his older brother. Mr Adams wanted to join in the family business after A levels and was hurt when father sent him off to university in Glasgow. His father died of cancer shortly after Mr Adams returned to Edinburgh with his degree. At the age of 30, while under severe stress at work, Mr Adams took an overdose of Valium. A year later, on the brink of a business failure, he took another overdose and cut his wrists.

When he was 40, Mr Adams came to see me looking dishevelled and unshaven after he had gambled away all of his money - half a million pounds. He looked and sounded melancholic - feeling impoverished (as he was in reality), slighted and unjustly treated. He told me that when he went to a casino he often started with a little money but soon won thousands, only to lose it all at
the end of the night. His older brother had taken over his financial affairs, blocked all of his bank accounts, left him with a weekly allowance and went off to Japan for a holiday. Mr Adams said that he felt suicidal and then made a slip, saying 'father' instead of 'brother' had left him and gone off to Japan. When I called his attention to his slip he referred to his suicidal thoughts and added, 'it all started with my father's death'.

After Mr Adams' father died, his mother confided only in him that she would one day commit suicide. In passing he said that his mother also confided to him that she had 'killed' her own mother with a drug overdose after she had a paralyzing stroke. After associating to his fear that his wife might leave him, Mr Adams added that he didn't understand why he always avoided his mother.

One month after Mr Adams started five times weekly analysis, his mother made a serious but unsuccessful suicide attempt at home in Edinburgh. Mr Adams wasn't surprised. 'I didn't go to see her because my brother is there. I'm glad he's upset and had to come back from Tokyo. I stayed in bed all day yesterday.' Mr Adams justified his coldness by referring to his family's very rational attitude to death. Without recognizing the failure of this defence, he described his father as 'paranoid, full of fear and panic during his last week. His face at the funeral home was distorted and ugly. I tried to push his lips into a calm expression. My mother is always calm.'

The next day he was furious that his brother advised him not to sell his shares to settle his debts, but to keep them and gamble that they would increase in value. I linked his rage at being put at risk to satisfy his brother's wishes for excitement with his mother's secret which had put him at risk as the passive, guilty accomplice, waiting for a predicted self-murder. I then took up what I thought was his fear that I would put him at risk by not taking seriously his earlier attempts to kill himself.

In the sessions Mr Adams regularly complained that I did not give him advice and suggestions. I interpreted this behaviour in the transference in terms of his view of me as distant and withdrawn and his efforts to get compensation for what his mother failed to give him by actively demanding more from me. This was often followed by transient regressed states featuring rambling and mumbled conversation and narcissistic withdrawal into drowsiness, which I interpreted as Mr Adams' identification with his narcissistic mother. This appeared to be what Pearl King (1978) refers to as a reverse transference, that is, the patient relating to the analyst in such a way to give the analyst the experience of the patient as a child by relating to the analyst as the parent had done. My interpretations seemed to have a positive effect and there were obvious signs of improvement in Mr Adams' appearance.

Mr Adams' gambling represented a manic solution to his feelings of helplessness, impotence and despair. I understood the self-defeating, self-impoverishing aspect of his gambling behaviour as Mr Adams dicing with death, particularly after his mother's suicide attempt increased his anxiety about his own survival. I was worried about the suicidal component of his gambling. As his wish to triumph over the odds intensified, I took up his pattern of losing money as a way of demonstrating his mother's failure by leaving him bereft and without resources. His failures also invited his mother to rescue him and it was now clear he wanted me to do the same. These interpretations also appeared to have an effect; Mr Adams stopped gambling. Furthermore, his attitude became more positive and he began investing again in his work and family.

At this point, Mr Adams interrupted his analysis in an optimistic frame of mind to go to Edinburgh, his home town, to try to generate business for his neglected company. However, once there business did not go well and he couldn't face his old friends. On a Sunday afternoon he felt lonely and suicidal and called his wife in London, hoping she would express sympathy and come to join him. Instead, Mrs Adams complained about his using suicide to blackmail her. She couldn't stand his threats any more and told him to get on with it if he was going to kill himself.

At first Mr Adams felt shattered, hurt, rejected and totally alone. However, once he decided to kill himself he felt great relief and calm. He took seventy 10 mg tablets of Valium and lay down feeling at peace. As the pills took effect he felt he was drifting off into another dimension. There was a sense of oneness, a merging into another kind of existence. He was found by accident and rushed to hospital in time. I was shocked when I heard the news. I felt that I had missed something and had let Mr Adams down.

I now want to report what I learned from Mr Adams after his suicide attempt and what I had learned by thinking again about what he had told me before the attempt. I compared my thoughts about Mr Adams with what I had learned previously from my other suicidal patients.

Counter-transference during a pre-suicide state

My assessment of Mr Adams' suicide attempt began with the fact that I was shocked when I heard the news. I assumed that understanding my response would shed some light on why I was caught by surprise. Sandler's (1976) concept of the analyst's role response provided a useful framework for considering my reaction. Sandler (1976) draws attention to the patient's unconscious attempts to provoke the analyst to behave in such a way as to confirm the patient's illusory (transference) image of the analyst. The analyst may hold his response to this prodding in his consciousness (King, 1978, referred to this as his 'affective response'), and make use of it to understand the transference. Failure to hold responses and the enactment of them in behaviour, attitude or remark represents the analyst's unconscious role response.

Sandler suggests that:
very often the irrational response of the analyst, which his professional conscience leads him to see entirely as a blind spot of his own may sometimes be usefully regarded as a compromise-formation between his own tendencies and his reflective acceptance of the role which the patient is forcing on him.

Sandler views this type of counter-transference reaction as a piece of behaviour or an attitude that results from the overlap of the patient's pathology and the analyst's. Consequently, the professional is only likely to become aware of his role in a counter-transference interaction by observing his own feelings and behaviour after the fact, after he has responded. Nevertheless, by viewing his counter-transference behaviour as related to the patient, and thinking of it as a compromise between his own tendencies or propensities and the role relationship which the patient is unconsciously seeking to elicit, the analyst can deepen his understanding of the transference and his part in the patient's suicide scenario.

It became apparent that an essential ingredient of the pre-suicide state is the patient's attempt to involve the analyst in an active way in the suicide scenario. Straker (1958) pointed out: 'A decisive factor in the successful suicide attempt appears to be the implied consent or unconscious collusion between the patient and the person most involved in the psychic struggle.' The unconscious collusion is buried in the analyst's counter-transference.

Asch (1980) has demonstrated the vulnerability that the therapist of the suicidal patient has to being provoked into negative counter-transference attitudes which are experienced by the patient as collusion in the suicidal fantasy. This collusion confirms for the patient the analyst's active participation in a regressive sadomasochistic fusion, places the therapist in the role of the executioner, and gives the patient justification for retaliation via a suicide attempt.

The sadomasochistic dynamic may also manifest itself in the subtle, superficially benign form of the patient's feeling of being at peace which contributes to increased self-assurance and confidence (Lauffer and Lauffer, 1984). Depressive affects, anxieties and conflicts are no longer communicated. This narcissistic withdrawal cuts the therapist off from moods and behaviour which would normally elicit an empathic response of alarm or worry and may result in the sudden loss of subjective emotional concern (Tahka, 1978) for the patient.

In a narcissistic regression, which dominated my patients during the pre-suicide state, there is the prospect of imminently fulfilling a merging suicide fantasy. As far as these patients were concerned, they were already at peace because they had crossed a rational barrier of self-preservation, identified the assassin/mother with their body, and had no doubts about killing it.

The analyst, burdened with anxieties about his or her patient's life or exhausted by the patient's relentless attack on hope or angry about being blackmailed

(1976, p. 46)

The father and the pre-suicide state

The questions remained, 'Who was I in the transference? Who was the object evoked by Mr Adams and enacted by me?' It was clear from Mr Adams that he felt distant and alienated from his father. The absence of his father in Mr Adams' material was consistent with their relationship. My failure to perceive and respond interpretatively to Mr Adams' suicide risk confirmed my role as the distant, uninvolved father. I had the impression that Mr Adams' father had failed his son during an early phase of development.

In normal development, both pre-Oedipal parents represent to the child the world outside the exclusivity of the mother-infant relationship, e.g. the realities of time and place and objects. For the purpose of this chapter I will only consider the role that the 'good-enough' pre-Oedipal father plays as friendly rival with both his child and his wife, in offering each of them a dyadic relationship that is parallel to and competes with the mother-child unit.

In 'good-enough' fathers the pleasure of procreation and the birth of his child is accompanied by feelings of envy and exclusion from the mother-child relationship as well as adjustment to a secondary role with the child. Initially, fathers can defend against this change by supporting the mother and making use of passive feminine aspects of their make-up to identify with the mother. However, a more active, masculine identification will emerge in the father's relationship with his child and wife.

On the one hand, the attractive and attracting father stake his claim on his child, and, with mother's help, enables the child to move from the exclusivity of the infant-mother relationship into an inclusive position as part of a pre-Oedipal triad.

Father's gender role identity and parental Oedipal impulses influence the idiosyncratic nature of the claim he makes on his child. For instance, his conscious and unconscious fantasies and anxieties about female sexuality will affect the way he relates to his daughter from the beginning. She may be 'daddy's little girl'. Gender influenced relating will also play a part in the way a father helps his son dis-identify from mother (Greenson, 1968) and father's view of the way his wife relates to his male offspring. The father may even be conscious of not wanting his wife to 'feminise' his son. Whatever form this process of claiming his child takes, and there will always be infinite variations influenced by mixtures of projections and reality, the child will become aware

(often before a holiday break from treatment). may be tempted to retaliate by giving up on his or her patient or using the patient's sense of peace to justify relaxing his therapeutic vigilance. In my case, external signs of decreased stress and improvement in the patient were used to defend against my unconscious wishes to retaliate by letting go of the suicide risk.
that he or she occupies a place in father's mind that is separate and distinct from mother.

The child also becomes aware of a place for mother in father's mind and a place for father in mother's mind. Father reclaims his wife by seducing her back to him and rekindling her adult sexuality. The father who reclaims his wife and engages his child on his own terms protects them both from lingering longing in a 'fusional' or symbiotic state and facilitates the separation and individuation process (Mahler and Golsiner, 1955).

Freud (1931) recognised this little girl's attachment to her father as a refuge from her first attachment to mother. Loewald (1951) referred to the child's positive, pre-Oedipal relationship with the father who stands for a paternal veto against the engulfing and overpowering womb which threatens to undermine the ego's orientation to reality and its efforts to establish boundaries between self and other.

The father's twofold response supports the child's right to an independent existence that is separate from mother while providing the toddler with a means of coping with its longing for her. Abelin (1978) postulates that at around 18 months this process results in an early triangulation in which the toddler identifies with the rival father's wish for mother in order to form a mental representation of a self that is separate and longing for mother. The good-enough father provides a model for identification as well as an alternative relationship to the child's regressive wish to return to a 'fusional' state with mother with subsequent anxieties about engulfment.

In the analysis of my suicidal patients it became apparent that they perceived their fathers as either withdrawn or actively rejecting them, and as having failed to claim their wives. Each patient had felt abandoned to their anxiety about surviving as a differentiated self when left with a disturbed mother.

The patients' suicide fantasies articulated in this present represents internalised early pathological relationships between mother and child and father. The pre-Oedipal father's role was often obscured by the patient's relationship with the mother which dominated the suicide fantasy and by the father's absence or ineffectiveness. However, it was during the pre-suicide state that the internalised father's failure to intervene in the pathological mother-child relationship became most critical.

Discussion

It was clear that Mr Adams intended to kill his body while maintaining the fantasy that part of himself would survive. After taking the overdose Mr Adams felt calm, as he had described his mother, and expected to pass into 'another dimension' and wondered what it would be like.

A detailed analysis of Mr Adams' suicide fantasies would take us beyond the aims of this chapter. I will not develop further Mr Adams' identification with his suicidal mother (for instance, while talking about his suicide attempt he made a slip saying his mother was 40 - his age). It also emerged in his analysis that Mr Adams hoped that his suicide would serve as revenge against both his parents.

Mr Adams' suicide fantasy was organised around a sadomasochistic relationship with his mother whose shared secret had tortured him by making him an accomplice in a homicide (the overdose that she had administered to her mother) and her own planned suicide. His mother's unsuccessful attempt on her life increased his guilt because he had ignored her explicit warnings that she would kill herself. His fear that she would kill him increased as well. He slipped in telling me of his mother's suicide attempt, saying 'My mother tried to kill myself.'

Mr Adams felt his father did not relate to him in his own right. For instance, father could not support his son's wish to join him in the family business. Mr Adams associated feeling suicidal to being left by his father, and then recalled that his suicidal fantasies started with his father's death. However, Mr Adams felt abandoned to his mother by his father long before his father's death. Father and brother had paired off while he was left with mother. Without his father as an alternative object with whom to identify, Mr Adams was left in a masochistic tie to a murderous mother.

Although Mr Adams' suicide fantasies were the outcome of a pathological bond with his mother, during the pre-suicide state his relationship with his father, particularly father's failure to protect him from his mother, functioned as the sanction of the suicidal act.

Mr Adams relied upon splitting of the self and the object to survive his mother's suicide attempt, which he experienced as an attack on his life. The resulting suicide fantasy during the pre-suicide state had two components: an unconscious fantasy and a delusional conviction. Mr Adams' unconscious fantasy which identified his body with a bad mother initially came into the analysis as non-verbal communications in his neglect and mistreatment of his body. After his suicide attempt this identification was put into words by Mr Adams: 'Mother couldn't care for her body and she couldn't care for mine. How could I care for myself?' Getting rid of his good mother, now identified with the object of his suicidal attack - his body - would make it possible for his split-off surviving self to merge with the split-off idealised mother - the nameless 'other dimension'.

There was a breakthrough of his unconscious identification of his body with his mother and his sadistic revenge against the bad mother, represented by his wife, when he made a slip: 'I can't say to my wife 'I want to kill yourself.'

2 See Barnett and Hale (1985) for an analytic study of a son's guilt following his father's suicide.
The fantasy of merging with an idealized mother (which was on his mind when he took the pills) became a delusional conviction during the pre-suicide state.

Mr Adams' slip of the tongue, 'My mother tried to kill myself', represented a breakthrough of a preconscious awareness of mother's sadistic attack on him via her suicide attempt and formed the basis of his identification with the aggressor. In proceeding with his suicide plan Mr Adams turned passive into active, and shifted from a masochistic to a sadistic role, in order to extract revenge. Mr Adams' depression lifted as he planned the details of his execution which included collecting Valium tablets, returning to his birthplace, and deceiving others about his intentions by appearing more sociable and optimistic. He stopped gambling. In sessions he talked about his earlier suicide attempts as well as his mother's attempt on her life.

At this critical point in the analysis I saw myself, in retrospect, as a guard going to sleep at his post. In this case, the decisive factor in precipitating the suicide attempt was the relaxation of my vigilance regarding the suicide risk, a lessening of my empathic contact with the patient, and an enactment of his father's withdrawal and failure to stake a claim for his child's right to a relationship with him by not protecting Mr Adams' analytic time and place with me. Later, in his analysis, it became clear that fantasies enacted in his gambling had been displaced on to his suicide fantasy including the belief that he would omnipotently triumph over the loss of his father and be chosen by fate/mother. The pre-suicide state, like gambling, is a manic flight from judgement into narcissism. Mr Adams was unconsciously in the grip of a repetition compulsion and had tested me to see if I would repeat his earlier experience with his father. My role response to Mr Adams' behaviour (e.g. an apparent improvement and the undetected meaning of a narcissistic withdrawal) coincided with his breaking of the analytic structure (by cancelling sessions) which I failed to prevent. My failure was experienced by the patient as a failure to maintain the reality of our relationship, that is, the realities of time and place, thereby leaving the patient without an alternative to the timeless merging fantasy of his suicide scenario. Mr Adams left me to return to his mother. I failed to analyse the merging fantasy that was gratified in this way and the destructiveness inherent in it.

My empathic failure was experienced by Mr Adams as an enactment in the transference of the neglectful pre-Oedipal father who sanctioned his youngest son's return to a seductive and 'murderous' mother. In this way, I unwittingly entered into and played a role in the patient's suicide fantasy.

3 Limetani (1991) has observed a similar counter-transference phenomenon in the analysis of overt or latent homosexuality in males and females.

Summary

Just prior to attempting suicide Mr Adams cancelled his sessions. At the same time, I underestimated the imminence of the suicidal act. There is no explicit or implicit suggestion that these two features occur only with suicidal patients, but these features may have particular meaning during a pre-suicide state.

The analysis of a pre-suicide state based on material from before and after Mr Adams' suicide attempt illuminated the father transference which had been enacted in my counter-transference and the cancelled sessions. The transference was to a father who failed to claim his child for himself, who abandoned him to a smothering, 'murderous' mother, and who did not offer an alternative to an exclusive mother/child fusion. The father had not stood in the way of a regressive pull to a sado-masochistic relationship with mother which formed the core of the suicide fantasy. This experience of the abandoning father was reversed by the patient who, in turn, left the analyst to join his mother - in death.

References


