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# Empathy and Secrecy: Discovering Suicide as a Form of Addiction

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Abstract:

This paper is about the complexities of working with suicidal patients by focusing on the concept of suicide addiction. Based on the author's successful extended psychoanalytic work with a suicidal patient and informed by her long experience with the methods of Heinz Kohut's empathic attunement, she proposes that some patients conceal their suicidal thoughts and use them, as others use alcohol or drugs. This suicide addiction, as it came to be seen through therapy, contained all of the characteristics of addiction with a particular emphasis on secrecy.

It is also proposed that a significant number of suicidal patients are addicted to thoughts of suicide. The aim of this article is to share this understanding with other clinicians and to the public, to alert them to particular signs that characterize the patient whose own death has become a secret obsession.

Keywords: *suicide, addiction, trauma, secrecy, empathic attunement, suicide prevention, PTSD*

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When Claire walked into my office for the first time, she told me that her children were almost grown and would soon be leaving for college. She knew that she needed to have some changes in her own life. "I want to have more fun," she said. "My children have held that place for me, and I know that they must get on in their own lives. And I must find more to enjoy in my own." Little did I know then the irony of that statement. It was not until we had been meeting for months that I came to understand that her enjoyment was in dosing herself on thoughts of killing herself. What she meant as "living more" was in giving action to these thoughts – that suicide had become her drug and that I had become its witness and its warden.

By working with one particular patient who is so addicted, I came to understand that there are grave differences between one form of suicide and another; that part of our inability to prevent suicides is that we have not been widely aware of this fact. The confusion over the root causes has led many mental health practitioners to err in their approach to helping certain patients. A

report from the U.S. Department of Health and Human Services in 2001 shows the value of better awareness of different types of suicidal patients: "Many persons who commit suicide have contact with healthcare providers in the time preceding their deaths. This suggests a widespread inadequacy in identifying and assessing at-risk persons by healthcare professionals and numerous studies have concluded that healthcare professionals lack sufficient training in the proper assessment, treatment management, or referral of suicidal patients" (USDHHS, 2001).

I believe that a significant number of suicidal patients are addicted to thoughts of suicide. I hope to pass on my understanding to other clinicians and to the public to alert them to particular signs that characterize the patient whose own death has become a secret obsession.

What is suicide addiction? It is when the addict obsessively thinks about his own death. Obsessively thinking about suicide is as mood-altering as any psychotropic drug, but unlike drugs, suicidal thoughts are always available. These thoughts are then employed as a "fix" for emotions that cannot be dealt with directly. This thinking leads to attempts, and, if untreated, can obviously lead to death. Suicide is an adrenalin rush that is fed first by thoughts and, at the next stage, by actions such as wrist-cutting, other forms of self-mutilation, alcohol and drug abuse or even intentionally falling off one's bicycle, i.e. by staging an accident. It is frequently triggered by the repetition of past trauma as in PTSD. There is often a history of mental and physical abuse, of silence and secrecy, that makes it difficult, if not impossible, to put feelings into words. In fact, trauma is its "common denominator" (Taylor, 2002, p.180).

The purpose of suicide addiction is the same as any other addiction. It acts as a pain control mechanism. It is an effort to gain mastery over forces that feel out of one's control. But what starts out as a pleasurable change from the anxiety or anger or sadness that was briefly felt, can end in a trance-like state, a sense of such total euphoria that it leads to death. The feeling that could not be tolerated is numbed. The sense of powerlessness that the feeling engendered is replaced by a sense of power. What gives greater strength than knowing one has control over one's own death?

Many suicides in the military where trauma and adrenalin rush are parts of everyday life could easily be of this type. I have read that, on average, one active-duty soldier is killing himself each

day--twice the number of combat deaths and twice the civilian rate of suicide. Some factors that account for this are depression, PTSD and substance abuse. Kevin Taylor writes in *The Seduction of Suicide* that "The suicide addiction cycle is a complex mixture: it is both inherently traumatic and a response to previous trauma. We have become addicted to trauma, as it were. There seems to be a good chance that the addiction is mediated through a complex biochemical pattern established by childhood trauma" (Taylor, 2002, p.180). The emotional shock and distress of combat superimposed on childhood trauma combined with drug and alcohol abuse becomes a very heady cocktail.

Suicide addiction should be differentiated from suicide that is the result of other causes such as clinical depression or other types of mental illness. Should suicide have a category of its own in the diagnostic manuals that we use to guide us in treatment? My response is a desperate, affirmative one. In the new DSM-5 Diagnostic Manual, there is an acknowledgement of suicidality as an item of concern that must be addressed in every psychiatric evaluation. A person is considered suicidal if there has been an attempt made in the last twenty-four months. It is also determined by the amount of involvement the person displays in planning and in attachment to the idea. This directly touches on obsessive thinking about suicide that can lead to addiction. The form of suicide that I describe here has at its center the word "addiction." It is marked by all the characteristics we have come to understand in working with alcohol and drug addiction, but it has some unique attributes as well. As in so many addictions, it is anchored by depression, but without obvious traits of depression. Detection, therefore, can be easily missed even though depression and suicide have historically gone hand in hand. On the contrary, a person who is obsessively thinking about suicide and seeking help, may appear cheerful and in control of his feelings even while being unhappy with a specific situation. The adrenalin rush caused by keeping the secret and the feelings of control it triggers could account for this.

Addictions are defined by various characteristics, according to Taylor. I will paraphrase some of them as they apply to the suicide addict:

1) tolerance and the need for increased amounts of the thought;

2) withdrawal or cutting back on social or recreational activities as a result of use;

3) use in larger and larger amounts over longer periods than intended;

4) persistent desire or unsuccessful attempts to control it;

5) continuing the habit despite knowing that it creates problems.

I maintain that the most important characteristic of suicide addiction is secrecy. Although alcoholic and drug addicts may have their hidden cupboards, their addictions are not fed by concealment. Secrecy is crucial to maintaining the power of suicide addiction. It is at the heart of the obsession. It is the wall that is built between reality and fantasy. It makes the real world a foreign territory, for the terrain lies within the fantasy world of the addict, and that fantasy world must be kept concealed if the addict is to feel safe. As with all addictions, an adaptive function is being served. Specifically, it is the feeling of having a safe haven, where the suicide addict has total control of what happens: no one can get in, and only the addict can get out. And, there are only two exits: re-entry into reality or suicide. Unless the patient finds that there might be an alternative safe space, he is not likely to share the secret. A new "safety zone" can grow out of the dyad of the patient and therapist. But this will only happen if the patient feels understood. As per Heinz Kohut (1971, 1984), one way of making that connection is through empathic attunement.

We all know that empathy is an essential component of being a psychotherapist, but Kohut went further in elaborating on it as a cornerstone for his psychoanalytic theory of the Self. He thought that it was a quality in nature, essential to our being human, and as much a part of us as sight, sound, taste, and smell. Almost everyone has empathy; but Kohut (1984) fine-tuned it as a working technique. It is in understanding the experiences of our patients and in seeing the world in the way that they do that we are able to enter their worlds and to connect with them. For some patients it is their first experience in feeling understood, and it acts as a curative agent on its own. But always it is a means of data collection to inform treatment. Empathic attunement, Kohut wrote, is "vicarious introspection . . . the capacity to think and feel oneself into the inner life of another person..." (Kohut, 1984, p.82).

Once this is accomplished, there are endless worlds that open up. Donald Winnicott quotes Rabindranath Tagore: "On the seashore of endless worlds, children play," and then writes that

he was haunted by this line until he saw it as a metaphor for a transitional space created by the mother-and-child dyad (Winnicott, 2005). Harriet Kimble Wrye and Judith K. Welles (1994), in their book *The Narration of Desire*, call it the "narrative space" (p.18). It is the space where the dyad, now of the patient-and-therapist, co-creates a narrative in which the unknown becomes known, and eventually understood.

And here lies the danger. Sustained empathic attunement requires an unflinching view into the patient's world. We are witnesses with no control over what is being portrayed. At the least, this can feel overwhelming. Or, it can feel as though we are drowning in that world. And often with Claire, I had an image of our being tied together at the waist with a long rope between us. It seemed that I was standing on a wooden raft in the middle of the ocean, and she was in the water at the edge of the raft. It was our job together to pull her out onto dry land – onto that seashore where understanding takes place and change is initiated. That feeling of tipping off the raft into the sea with her was the equivalent of my adrenalin rush. It occurred when she was in the grip of suicidal impulses. It was this balance between being in the grip of those feelings – hers and mine – and lugging us out onto the shore, where reason could take over; that marked the success of treatment.

Enactment is a big factor in treating the suicide addict. Because these are people who have had to disavow their feelings, they often have not developed any language for expressing those feelings. The stage is set, therefore, for acting them out. If the therapist is feeling numbed either because the patient's trauma touches on his own or because the sheer fright of watching someone court death overwhelms him, then there is added danger. If the therapist feels overwhelmed by the patient's experience, he may abruptly abandon the empathic stance causing a breach for the patient, who might then leave therapy feeling misunderstood, rejected or abandoned. Suicide is the obvious risk here or the behavior being re-enacted will continue to the exhaustion of each participant. When this is the case, trust in the therapeutic alliance is the glue that keeps the dyad together until understanding transforms the predicament.

With courage and willingness, these feelings that are most frequently the result of past traumas triggered in the present can be understood. They will then lose most of their power. But it is the tool of empathic attunement that gives us entry into the traumatic world of the addict, and it

is responsible for eventually making that "suicide space" feel unnecessary. Because the secret has been shared, the addiction is blocked and a loss of its power results. This serves to make the addiction harder to get back into, and sometimes the effort required, acts as a deterrent.

So it came to be with Claire. It was by being empathically attuned that one day out of nowhere, it seemed, she was saying that she wanted to kill herself. I had been dissatisfied with our work together. It had had a false feel to it that I could not understand. Sessions were dull. I had a sense that I was tiptoeing around the mouth of a huge crater, but with no symptomatology that seemed to fit any definitions of depression, or character disorder, or anything else from the DSM-IV. I could not dismiss my intuition. So, I sat there. And I listened. And I felt uncomfortable, because I could not know what was really there until it entered the room, like a bolt of lightning.

I had remarked to myself early on in the session that her manic state was at odds with her recital to me of the pressures at work. Ignoring her words, I went directly to her affect and said, "You are really excited today." She replied, "Yes, I have all these projects to get done. My boss left me 37 emails in two hours. I forgot to eat all day." I replied, "And it looks to me that you didn't get much sleep either." She said, "Well I went into work at 4:30 a.m. because there was no sense in lying there. I said, "Your head must be ready to burst," in my most empathic voice. "Yeah," she said, "It feels so big. Everything is so bright. So clear. So separate. I feel so strong." I was beginning to experience a feeling of fear. She was describing sensory deprivation in a positive way. Her mood seemed inappropriate to the situation. She continued, "I could do anything right now. I feel so strong. I could certainly kill myself."

It was a surprise to both of us, but there it was blurted out in the silence of that room. "I want to kill myself," she repeated in an excited and enthusiastic manner. I could feel my own heart race, and I immediately went into action and told her that I must call in an assessment team with a view towards hospitalizing her. I did.

The suicide assessment team came with their silent sirens. But she was nothing if not clever, and she could not be deemed suicidal at the time of their arrival. They left. That is when she and I staring at each other realized that there was another presence in the room with us, and that

presence was Death. She turned away from me to gaze at Death with pleasure and delight like an innocent child playing with a scorpion. I gaped at this mirage with feelings of dread, fear and anger, but also, I understood her experience of delighting in Death and the welcome relief it brought her. Our mutual recognition of this presence caused it to skitter away, at least for that time.

Now that her secret was "out of the closet," she became less secretive about her obsession. Her addiction was triggered by many things. There were past traumas that were being reenacted in the present causing her such deep emotional pain that she felt they had to be obliterated. Also, as her defenses changed, she experienced feelings of vulnerability that she had not allowed herself to recognize before. This gave her added reason to need her suicide space in order to feel "safe." She also became more aware of her anxiety as it manifested itself in her need to perform well at her highly pressured job. As in her childhood when she felt compelled to perform perfectly in academics or in sports to gain her mother's approval (which never occurred), she would get the same adrenalin rush now by saying that she could pull that all-nighter for her boss and save millions for the company because she was going to kill herself anyway. Here the suicide addiction helped her to pull herself together to focus, to rid herself of the anxiety of possible failure, and to perform Herculean tasks that brought her satisfaction but never, however, lasted for very long. She would think," If I am going to kill myself, and I alone have the power to do so, then I have the power to do anything and everything." This grandiose thinking was the restorative function of the addiction. But as with any other addiction, as tolerance developed so did the need for more elaborate thinking to achieve the same effect as before. These embellishments lead to rituals and then to attempts at suicide. In this way her cycle of addiction progressed. There were many times when she became dissociative and suffered periods of time loss and fugue states. Her attempts at suicide were staged as accidents. Claire had been a "cutter" since adolescence. Self-mutilation had long been a habit. Harming her body came effortlessly to her.

Telling her that I could not let her die, I insisted that she have a psychiatric assessment. She had two from two different knowledgeable psychiatrists, and then there were three of us who

were baffled. She tried medications. They were not helpful at this stage. Nothing seemed to help except the functions that I served for her, but I only learned this as time passed.

Meanwhile I was left to deal with the counter-transference issues. This was a dangerous patient with whom I was connected. She could well suicide leaving me with an aching sense of loss and failure. She could engulf me in her world so that I was not sure at times how to lead her out of it. She could make me question my work because I had to invent new ways of being effective with her. I am a psychoanalyst, but I also had to function as an addiction counselor. My professional identity was challenged, and at times, my personal traumas were unearthed, and I had to work through them.

Given the great difficulty of working with suicidal patients, it is no wonder that we psychotherapists miss what, in hindsight, appears to be obvious. But if we can isolate symptoms and piece together a template of characteristics, then we have a structure in which to assess a patient who comes to us for help but is forthcoming in nothing else. Empathic attunement will place us in his shoes; but then we must be prepared for all the hard work that follows the entry into the mind of someone who is obsessed with the thoughts of suicide. For this we need support from other professionals who are aware that certain patients who come to us for help are highly ambivalent about receiving it because it takes them away from the addictive nature of these thoughts. They are lured into feeling safe in the arms of death.

We need support from colleagues who understand the process, and we need support groups for those who are trying to overcome this addiction. An entire system must be put in place if we are to break into their devotion to death, in order to help these patients move away from the edge. As they come to understand more about the way that their emotions are working, they will build inner strength, which will give them the power to live again – in the world of reality.

It is crucial that mental health professionals be aware of the hazards of dealing with suicide. Suicidal thinking is too frequently missed, not only because our patients need to keep their secrets, but also because we can unwittingly aid and abet their concealment. Because there are ethical, legal, and moral ramifications that weigh on us as professionals, as well as a universal taboo against the act of suicide, we can unconsciously resist getting to know these patients.

Historically, suicide has warranted punishment, as in the church refusing burial in consecrated ground. Our legal system, which requires that suicidal patients be hospitalized, is helpful, but it can also invoke a tumultuous response that often isolates the attempt of suicide from the person committing it. That is, it attempts to treat the "symptom," but in so doing, it can cause the underlying problem to bury itself in even more secrecy. The more aware we are of our limitations in dealing with suicide, the more successful we will be in creating a trusting relationship with the suicide addict. Honesty will follow, suicidal thoughts will be unloaded, and ground rules will be made for dealing with hospitalization in the event of relapse.

A quote from Elizabeth Appell (attributed to Anaïs Nin once) perfectly describes Claire's progress: "And the day came when the risk to remain tight in the bud was more painful than the risk it took to blossom." That day arrived for Claire when she brought me a written contract that she had spent hours drawing up. In it she finally committed to treatment and made rules for her behavior and for my responses to them.

Since then a lot of time has passed. Claire is increasingly able to tolerate feelings of all kinds including both anger and love. She has come to appreciate her husband since she has been able to know him for who he is, and not for what she wants him to be. About the time of the contract, Claire received a promotion at work that placed her in charge of many employees. She is now able to make appropriate demands on them, instead of doing their work for them and giving them the credit, which she had always done in the past. She has also been able to place limits on a highly demanding boss. By getting in touch with her own needs, she has found alternative creative ways of getting them met. There are still times when she makes forays into her suicide space, but these periods are shorter and getting into that space is harder to accomplish. Her appearance, too, has changed. It is softer, more decorative, and a testament to her increased feelings of self-worth.

Sometime ago, I realized that I had stopped worrying that Claire would suicide. We are both now on dry land. As her life grows richer, we continue to understand what happened in her past that contributed to all of this. She has said that if I "hadn't seen through her," she would not be alive today. Then jokingly she adds, "But I can change that at any time." ... We both know that neither she nor I would change a thing.

## REFERENCES

Kohut, H. (1971). *Analysis of the self.* New York, NY: International University Press.

Kohut, H. (1984). *How does analysis cure?* Chicago, IL: The University Press.

Rowe, Jr., C. E, & Mac Isaac, D. S. (1989) *Empathic attunement*: *The "technique" of psychoanalytic self psychology.* Hillsdale, NJ: Jason Aronson, Inc.

Rowe, Jr., C.E. (2005). *Treating the basic self.* New York, NY: Psychoanalytic Publishers.

Taylor, K. (2002). *Seduction of suicide: Understanding and recovering from addiction to suicide.* Bloomington, IN: 1st Books Library.

U.S. Dept. of Health and Human Services (USDHHS) (2001). *National strategy for suicide prevention, goals and objectives for action.* Rockville, MD: Public Health Service.

Winnicott, D. W. (2005). *Playing and reality*. London, UK: Routledge Classics.

Wrye, H.K., & Welles, J.K. (1994). *The narration of desire*: *Erotic transferences and countertransferences*. Hillsdale, NJ: Analytic Press.

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