Making the Alliance and Taking the Transference in Work With Suicidal Patients

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This article focuses on two components of psychodynamic psychotherapy with suicidal patients. First, the value and importance of establishing and maintaining a clearly defined therapeutic alliance is noted and explored. A carefully negotiated alliance can become an edge or boundary across which the survival of the therapy, as well as the patient, can be negotiated. Attention to the vicissitudes of the alliance is hypothesized to be the central initial therapeutic action with suicidal patients. Second, the author explores the importance of “taking” rather than “refusing” the transferences offered by the suicidal patient, particularly negative and erotic transferences. Case examples are offered as illustrations.

Suicide is not easy for us to bear, but since there are only two kinds of psychiatrists—those who have had a patient commit suicide and those who will—it is something we must be prepared to face, even as we strive to prevent it.

After completing a psychiatric residency more than 20 years ago I found myself eager to learn how to make dynamic psychotherapy work for these patients. In search of an answer, I entered a four-year fellowship in psychotherapy at the Austen Riggs Center, undertook a personal analysis, and eventually joined the staff. At first I felt lost and helpless in the work with treatment-refractory suicidal patients, while filled with awe and curiosity about the wisdom of more senior therapists who seemed to get their patients through these crises more readily than I. I wondered what they knew that I didn’t about how to make dynamic therapy work. Gradually I developed a modicum of success in moving the treatments I conducted away from chronic crisis management and into a more meaningful engagement of the determinants of the crisis. As Riggs’ Director of Admissions I have had the privilege of doing close to a thousand consultations to struggling treatments over the last 20 years. Most of the people I have seen in admission consultations have struggled with suicide. Most were involved in outpatient treatments that had, for one reason or another, become chronic crisis management, with the therapist on the ropes, struggling to recover from the last crisis or fend off the next and having lost all hope of settling down to the interpretive work.

Each discipline has its own way of becoming stuck in the quagmire of chronic crisis management. In the face of increasing suicide risk, nonmedical therapists may delegate concern about survival of the patient’s body to a prescribing psychiatrist or to an inpatient psychiatric unit. In the process, there is a danger the patient’s lethality may be split out of the therapeutic work. The therapy may be seen as going well while the patient is dying. Sometimes psychiatrists take over treatment responsibility with or without delegation from nonmedical therapists, because the psychiatrist is where the buck stops when it comes to treating difficult patients in our behavioral health system. As patients become increasingly suicidal, psychiatrists often withdraw into the medical model, becoming increasingly zealous in their prescription of somatic treatments while viewing the patient’s biologically based “disorder” as exacerbating. In such situations, psychiatrists may leave little room for exploring the meaning of the patient’s suicidality.

### Principles for Working with Suicidal Patients

My experience in the admissions role reinforced what I saw in my own and my colleagues’ work. In previous publications, a set of principles (listed in Table 1) was formulated to help make dynamic therapy work by establishing and maintaining a viable therapeutic alliance with self-destructive and suicidal patients of the sort who generally meet criteria for the diagnosis of borderline personality disorder. These principles offer one useful approach to establishing and maintaining a viable therapeutic alliance with self-destructive and suicidal patients. The present report is offered in the hope of accomplishing two things. First, I want to explain how these principles help make dynamic therapy work with a suicidal patient. I am mindful that they are not the only answer or the only way of doing things, but they may help therapists stay in role and on task in the therapy when suicide is a prominent issue. Bearing intense countertransferences is facilitated by having guideposts to help us define the boundaries of the relationship and locate responsibility where it belongs. Second, I want to explore in some depth one of the principles dealing with the therapist’s contribution to self-destructive and suicidal behavior. The focus on this issue is not meant to invoke needless and inappropriate guilt in therapists, but to encourage careful self-examination and reflection in this difficult, high-risk work.

### How the Principles Work

The principles differentiate between suicidal behaviors that are and that are not potentially therapy-ending.

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**TABLE 1. Principles in the dynamic psychotherapy of self-destructive patients with borderline personality disorder**

When self-destructive behavior is potentially lethal, establishing and maintaining a workable alliance can be facilitated by:

- Inclusion of self-destructive behavior in the therapeutic contract from the outset.
- “Metabolism” of the countertransference.
- Engagement of affect.
- Nonpunitive interpretation of the patient’s aggression in the decision to end the treatment.
- Assignment of responsibility for the preservation of the treatment to the patient.
- Search for the perceived injury from the therapist that may have precipitated the self-destructive behavior.
- Provision of an opportunity for repair.

**Note:** Adapted from Plakun 1994.”

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They recognize and differentiate the roles of therapists and patients in the therapeutic work vis-à-vis suicide, and they give each participant a differentiated responsibility for maintaining the continuity of the therapy and for determining if the therapy should continue after a suicide attempt. The principles have the effect of making suicide an interpersonal event with intratherapeutic meaning. Further, they make a problematic symptom a high-priority focus of the therapeutic work.

The working notion is that any upsurge in suicidal threat means the patient is considering ending the treatment. Therefore, a search for the interpersonal reason for that shift is indicated. Suicide is established as an edge or as a boundary issue across which a dialogue about the survival of the therapy occurs. This boundary-setting does not ask the patient to relinquish the wish to die by suicide, but only to relinquish the freedom to operationalize dying if he or she wants the therapy to continue. It is a position consistent with the fundamental importance of differentiating thought from action. In the face of a strong positive transference attachment, this can be a powerful counterbalance to the potential for suicide while supporting the unfolding of the essential interpretive work.

The principles introduce a parameter to the therapeutic work. They also frame the issue of the patient’s choice and responsibility in the therapy. It is not simply, “If you attempt suicide, I’ll quit as your therapist,” but “If you attempt suicide, it inevitably is a choice to end our work. What is going on with us that makes you want to end our work? How have I pushed you to that choice?”

THE PRINCIPLES AND THE THERAPEUTIC ALLIANCE

The principles become integrated into the negotiation of the therapeutic alliance with suicidal patients. They become part of the frame that establishes and “holds” the therapy and defines the differentiated responsibilities of each participant. I would propose that keeping the focus on establishing and maintaining the therapeutic alliance, and then using the vicissitudes of the alliance as the crucial edge or boundary across which the therapy is conducted, is the highest priority with a relentlessly suicidal patient. The interpretive work is generally secondary when the patient’s survival between sessions is in question, serving primarily to illuminate why the patient would need to defeat the therapy through death and what has led to the loss of the alliance. The more central suicide is as a concern, the more the state of the alliance is, and must be, the major focus of the therapeutic dialogue. In fact, I think this is what Linehan and colleagues recognize and why it works, although there is no place for interpretive work in her cognitive-behavioral treatment modality. The following case example illustrates some of these points.

A male therapist worked with a relentlessly suicidal woman, the depth of whose attachment to him kept her alive, or so she said quite explicitly. The patient was a woman of 23 who had grown up in a loving, religious family in circumstances of rural poverty. She had a treatment-refractory depression and underlying borderline personality disorder, with more than 50 hospitalizations for overdoses taken with suicidal intent or for burning herself with cigarettes.

In accordance with the principles, the therapist did not focus much on the burning, although he commented on it from time to time and, in the process, learned about its relationship to intense self-loathing and the belief that she deserved punishment. Although much of the time she sounded like someone deeply committed to the alliance, the therapist had the discouraging experience of discovering one instance after another of her hoarding medications for an overdose. Only the recognition that, in fact, he always learned about the hoarding before an overdose was actually taken (with two early and minor exceptions) mitigated the intense feelings of anger and betrayal, of impotence and futility that he faced in the countertransference each time he learned there was much less to their collaborative relationship than he thought.

He eventually became aware of the sadomasochistic enactment (see below for a discussion of “enactment”) into which he could drift at those moments. Therapist and patient explored the subtle ways his words had become as much a punishment as her burning. A kind of retaliatory sadism toward her for the hoarding of pills was revealed through tone and word choice, describing her actions as “duplicitous” or “deceitful,” with a perceptible edge in his voice. They were eventually able to negotiate the use of the word “dishonest” as more descriptive and less sadistic in describing her unilateral revision of the agreement under which he prescribed for her. In fact, an important moment in the work was her recognition that the therapist was not perfect and needed her honest feedback to help him understand what was happening between them and how best to be of use to her.

It is worth noting that neither the therapist nor the patient commented on another bit of the therapist’s retaliatory behavior. That is, the therapist had begun a pattern of arriving just a minute or two late for the sessions. He had a vague awareness that this probably had to do with his countertransference irritation with the patient for her repeated hoarding of medications, but thought nothing more of this.
because he routinely made up the time at the end of the session.

The patient’s relentless pattern of first making an agreement about medications, then breaking it and hoarding them, continued unabated in spite of efforts to negotiate with her and define the boundaries of the alliance, until a piece of interpretive work was done. Eventually, quite separate from any issue about pills, and with deep shame and doubt, the patient began to speak of her growing conviction that a number of fragmentary visual and somatic memories suggested to her that she had been sexually abused as a young child by a relative. There was something about long-standing dreams of rape, and new ones with a sense of being choked by something in her mouth, that led her to conclude she had been orally raped. The frightening truth that they could not possibly determine whether this was fact or fantasy was also an issue of significance in the therapeutic work—but, fact or fantasy, the problem with hoarding pills suddenly seemed clearer.

The therapist was able to see and to interpret gently to her that among the horrifying issues she was facing about the belief that she was raped as a child, there was something that related to the problem of pills in their relationship. He told her he realized that allowing him to be in charge of what went into her mouth and what she swallowed was more than she could endure. The therapist was not prepared to relinquish his expectation that if he were going to prescribe potentially dangerous medications to her, she would work with him and take them as prescribed. However, something about the realization of the meaning of such an expectation for her allowed them to develop a new way of looking at the problem. It also served as a model for the way the work might be deepened by taking the risk of revealing her experience. This interpretation did not make the problem entirely recede, although it made it more understandable in the context of her life history.

Subsequently the patient, who was on a monoamine oxidase (MAO) inhibitor, bought an ephedrine-containing over-the-counter cold tablet for an overdose. The patient had been carefully instructed that such ephedrine-containing compounds had to be avoided in combination with an MAO inhibitor because of the high risk of a potentially fatal hypertensive crisis. She reported to the therapist that she had held the ephedrine-containing pills in her hand with the intent of swallowing them; she had not taken them, but only because she was accidentally interrupted. This put the treatment in crisis again, with its survival in question. The therapist sought consultation with colleagues about whether he undertook a search within him- or herself, and with the patient, for what it was the therapist may have done that contributed to the patient’s move toward suicide. Such a stance does not imply that a therapist is at fault for a patient’s failure to keep the agreement about medications. This leads us to the issue of the therapist’s contribution to suicide.

In the case just described, the therapist learned something about the impact his absences and minor latenesses were having on the patient. Their impact was much larger than he had realized, and it played a role in the patient’s failure to keep the agreement about medications. This leads us to the issue of the therapist’s contribution to suicide.

Although the use of these principles puts the therapist’s impotence and vulnerability to the patient’s aggression regarding suicide squarely on the table, this does not let the therapist off the hook, because one principle emphasizes the importance of the therapist undertaking a search within him- or herself, and with the patient, for what it was the therapist may have done that contributed to the patient’s move toward suicide. Such a stance does not imply that a therapist is at fault for a patient’s suicide in the course of therapy. Rather, the stance suggests that both individuals in a therapy, as in any intense relationship, are involved in a powerful set of interactions that affect both parties. An effort to understand what is happening requires a look at the impact each participant is having on the other.

It is often the case that a treatment that has been proceeding reasonably well as a side-by-side collaboration has suddenly, through a suicide attempt, shifted into a toe-to-toe struggle to the death. Often enough this can be conceived of as a reversion to the “law of the jungle,” where, in retaliation for a perceived injury or empathic failure, the patient assaults the therapy and the therapist by attempting to end his or her own life. Cooperman has called this “the defeating process.”
Finding a way to join with the patient in a search for the perceived injury or empathic failure, unearthing what the therapist may have done, and exploring its link to the patient’s life history is fundamental interpretive work facilitated by attention to the vicissitudes of the alliance, and it offers a genuine opportunity to deepen the intimacy of therapeutic work, as was the case in the clinical example described above.

**TAKING AND REFUSING THE TRANSFERENCE**

Our work as psychodynamic therapists involves “taking” or “accepting” the transferences that unfold in the course of therapeutic work. We “take” these transferences and let them unfold in the service of understanding the patient’s experience and, eventually, offer interpretations that link the here-and-now experience in the consulting room to events in the patient’s past. Close scrutiny of precursors to a suicide attempt often reveals there has been some way in which the therapist has found the transference the patient has offered to be unacceptable. In such instances the therapist may be thought of as “refusing” the transference prior to the suicide attempt. Frequently it is negative or erotic transferences that are most difficult for therapists to tolerate. The following case illustrates a problem with “taking” or tolerating the negative transference.

A psychiatrist began outpatient therapy with a treatment-refractory depressed and borderline woman of 30 who had an abusive brother and highly anxious and intrusive parents. The woman struggled with intense self-loathing, extreme rejection sensitivity, recurrent suicidal ideation, and a history of many attempts, and had been hospitalized 15 times. The therapist’s initial stance regarding her suicidal feelings was that he would not support her goal of suicide, but understood she was not ready to entirely renounce it either.

A month into the therapy the patient was hospitalized after a major overdose taken with suicidal intent. Both the therapist and the patient’s family insisted on a family meeting if the therapy were to continue. The treatment continued with a revised contract. The patient was given the responsibility to keep herself safe and to let her therapist know if this posed a problem. The patient asked her family to allow her to proceed in therapy without contact with them for a while in the service of her therapeutic work, but the family ignored this request and continued frequent intrusive contacts with her. The patient became less emotionally available, more disconnected, and increasingly angry and suicidal, and the therapeutic work entered an impasse as it degenerated into chronic crisis management.

The therapist referred his patient to Austen Riggs for admission. In the admission consultation the patient was initially quite guarded and unavailable, but she became more open when the consultant responded nondefensively to her request that he tell her what he already knew about her from her therapist. As they explored the way she was testing the consultant in this request, he learned she had also recently angrily insisted that her therapist allow her to read his notes about her, which the therapist did quite readily and without question or exploration. She explained she made this request in the hope of feeling safe and accepted by him, rather than looked down upon. When the consultant advanced the notion that the therapist’s ready assent to the record review may have deprived her of the opportunity to struggle with her ambivalence and uncertainty in the request, the patient was intrigued. As they explored this further, she was able to voice her dissatisfaction that the therapist had not stood up to her intrusiveness any more successfully than to that of her intrusive and anxious family. She feared the therapist was not really up to handling her or her rage, which she felt she had to hold back from him in the sessions. She realized that what she could not bring to him directly she brought indirectly, through the assaults on herself that were putting her treatment into an impasse and herself at risk for death.

Although the possibility of admission was offered as an eventual option, the consultant suggested she first return to her outpatient treatment and find a way to let her therapist know of her rage and her fear that he could handle neither her angry intrusiveness nor that of her family. He also suggested she explore with the therapist her role in inviting the intrusions she feared. After all, her overdoses and brinkmanship regarding death hardly encouraged her family to stop intruding into her life and treatment. Permission to speak with the therapist about the findings of the consultation was negotiated.

The therapist realized he had long struggled with tolerating her anger at him and that he had been avoiding a fight with her. The consultation and subsequent engagement between the therapist and patient about her anger at him had a nearly immediate calming effect on the patient. The work moved out of the chronic crisis management configuration. No admission to Riggs was necessary.

Virtually any transference may be refused by a therapist, but erotic transferences often are particularly problematic. One such case is described below.

A male trainee at Riggs worked with a young woman with an eating disorder and a history of suicide attempts who struggled with intense shame about an abusive sexual relationship. Her abusive lover’s contempt for her became indistinguishable from her own self-contempt.

A year into the therapy, the therapist was struggling in his supervision with the patient’s growing attachment to him and unfolding erotic feelings in the transference. Soon the patient came to a session after a formal family gathering
wearing the same provocative and revealing dress that had been part of ritualized sexual abuse with her lover. During the session she suggested her therapist was feeling lustful toward her. The therapist responded that he was not lusting after her, but rather felt she was humiliating herself in the suggestion.

The therapist unwittingly refused the erotic transference and actualized a sadomasochistic countertransference, recreating the contemptuous situation of the abuse. He thus unintentionally narcissistically wounded the patient, who responded within 24 hours with a nearly lethal overdose that required emergency treatment in an intensive care unit.

Most staff responded to this attempt with a sense of outrage and betrayal. The patient was seen as perhaps untreatable because of her antisocial character and primitive aggression. Through a determined effort to create a reflective space to review the transference and countertransference in detail, the therapist, supervisor, and other staff were able to get hold of what had happened, and to recognize the “hell knoweth no fury like a woman scorned” aspect of the patient's overdose in response to an injury from the therapist. Although the therapist felt too shaken and betrayed to resume the therapy, the patient was readmitted and continued in treatment with someone else.

REFUSING THE TRANSFERENCE AND ENACTMENT

Our work involves bearing our patients’ transferences and interpreting them. When we refuse the transference, we often do so because one of our own blind spots has been engaged. A rough edge of our character has been “hooked” by a bit of what the patient is struggling with in the transference, and we act out a bit of countertransference evoked in us by the transference. When we refuse the transference there is often a mutual projective identification going on, in which both therapist and patient project part of themselves into the other.9

The therapist unwittingly colludes with the patient in a process of mutual and complementary projective identification organized around events from the lives of both therapist and patient.9–11 This process of mutual projective identification is referred to as an “enactment.” When we refuse the transference we are often drifting away from therapeutic neutrality and into an enactment.9–13

Enactments are not bad, but rather inevitable therapeutic phenomena. Our task with enactments is to notice them and use them for the genuine opportunity they offer to deepen the therapeutic work. This is conveyed in the following quote from an earlier paper of mine11:

The evolving mutual projective identification of an enactment becomes a slippery slope on which the therapist is in danger of sliding away from the component of the therapeutic role that requires accepting the patient’s transference. . . . The ideal technique in therapy is not even to avoid enactments—as if one could. In an endeavor as complex as psychotherapy, enactments that put therapist and patient on a slippery slope are as inevitable a part of the work as a slippery snow-covered slope is to the endeavor of skiing. In fact, in both situations the trick is to learn to use the dynamics of the slippery slope to help get to the bottom of things. (p. 287)

Detecting and using enactments often requires us to seek an outside perspective, as from supervision or consultation with colleagues. Undetected enactments can lead to the kind of injury that a patient responds to with suicide. Such an enactment was part of what was illustrated in the first clinical case, in which, out of therapeutic zeal to prescribe for the patient’s treatment-refractory depression, the therapist unwittingly replicated oral rape with pills.

Sometimes the therapist has no awareness that a transference is present to accept or refuse and unwittingly steps into an enactment that pushes the patient toward suicide, as in the following case:

A woman in twice-weekly outpatient psychotherapy, previously a high-risk suicidal patient, had settled into a useful therapy once dissociated memories were unearthed of sexual abuse by a group of boys as a teenager. She had concealed these memories from her family and dissociated her own awareness of them in the context of her family’s deep religious convictions. She also revealed a history of sexual exploitation by her first psychiatrist, to whom she had been referred after becoming symptomatic following the abuse. He had used the threat of ECT to coerce her to submit to sex with him. She was terrified that her current therapist would inevitably perpetrate sexual abuse with her, too, but they seemed to have moved away from the brink of suicidal danger as they explored the historical and transferential antecedents of her mistrust, depression, and suicidality.

The patient was married to a gregarious and likeable professional whom the therapist met during an early joint meeting. His concern for his wife seemed genuine. One day the patient told the therapist she was pursuing a divorce. The therapist, who had himself been divorced after his wife left him some years earlier, asked what had made the idea of divorce come up, but learned nothing. Perhaps too quickly, he added Freud’s dictum that people in intensive treatment might do well to put off such big decisions as divorce or marriage. Before the next session the patient had
only accidentally survived a suicide attempt by carbon monoxide poisoning. The therapist felt betrayed, taken aback, and mystified. He let the patient know that her decision to seek death had effectively ended their therapy, since he had to understand her choice of death as a choice to end their work, but he was willing to continue to consult with her to try to sort out what had happened and to see whether there was any reason to renegotiate the therapeutic work.

In the consultation process the therapist learned she felt the therapist had been telling her not to divorce and that he was siding with her husband. Although she had not previously disclosed this, it now emerged that there was a sadomasochistic sexual relationship with her husband. He characteristically would awaken her in the night and force her to submit to various sexual acts, while he roughly bit, kicked, and punched her. The patient had been trying to muster up courage to leave this relationship, which replicated her past history of abuse. She had kept it out of the therapy because of fears she could not trust the therapist to stay in role if she discussed the details of her sexual relationship. The therapist had unwittingly, out of his own positive feelings toward this superficially affable man and his own lingering hurts from his divorce, taken a stand in favor of the preservation of the marriage. The patient felt once again trapped into submitting to sexual abuse by the psychiatrist she depended on to help set her free. For his part, the therapist’s anxiety about the patient’s apparently impulsive wish to divorce her husband had reminded him all too much of the painful experience of his own divorce.

Once the therapist could see his unwitting role in the enactment with her, they could explore it, rehabilitate the working alliance, and resume the therapy. They were also able to deepen the work as they explored the way she had set the therapist up through her silence about the abusive marital relationship and through her fears that he would be aroused by discussion of such issues. She went on to divorce her husband, graduate from college, complete therapy, and earn a doctoral degree. She was doing well at last contact 10 years later.

**CONCLUSION**

Work with suicidal patients poses a formidable challenge. All of the advances of psychiatric treatment have not, after all, diminished the risk of suicide as a cause of death. The ideas advanced here are intended to continue a dialogue about the challenges of the work, rather than to be prescriptive about the way to perform it properly. The point of view offered in this article about psychodynamic therapeutic work with suicidal patients suggests that the outcome of such work depends in part on the therapist’s success with three tasks: 1) careful negotiation of, and ongoing attention to, the establishment and maintenance of the working alliance; 2) recognition that the use of the vicissitudes of the therapeutic alliance may be the central initial therapeutic action in work with suicidal patients; and 3) “taking” the transference as it is offered, rather than “refusing” it, with careful attention to the way our countertransference-based inclination to refuse transferences may lead to enactments that can, unwittingly, give patients reasons to choose suicide over continuing the arduous therapeutic work.

Attention to these three tasks will not prevent all suicides, but it does offer a set of useful guideposts to help therapists struggling with difficult suicidal patients keep on task and on course in their therapeutic work. When all is said and done, though, just as oncologists lose patients to cancer and surgeons during surgery, therapists will lose patients to suicide. It comes with the territory.

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