“To be With or to Withstand?” Suicidality, Shame, and the therapeutic Encounter: Reflections from an IPA-Thinking Lab

Breznova, Daniela; Bristov, Jacqueline; Goldblatt, Mark; Laplanche, Nathalie; Lehmann, Anja; Lindner, Reinhard; Meyer, Marina; Mulieddo, Marzia; Rho, Wangu; Sadjiroen, Andreas; Sharp, Irene; Teising, Martin; Townsley, Judith; Wolscht, Eckhard

We had six online sessions between March 26th and June 4th 2025

ABSTRACT

This article explores the complex dynamics of suicidality in psychoanalytic psychotherapy through the lens of case material and clinical reflections from an IPA Thinking Lab. As part of that IPA initiative, a small group of IPA members and candidates met online twice per month, from March to June 2025, to discuss suicidality.

Drawing on vignettes, papers and collective dialogue, we have examined the psychic underpinnings of suicidal behaviour, therapist countertransference, and the dialectic between therapeutic neutrality and engagement in the psychoanalytic treatment of suicidal patients. Particular attention was given to the themes of shame, intrusion, psychic fragmentation, and the quest for a sustaining object.

For the purpose of this article, we have integrated these discussions with theoretical contributions, especially those offered in Mark Goldblatt’s work on suicidal adolescents, to illuminate the clinical and meta-psychological challenges of working with suicidality in both acute and chronic forms.

Keywords: Suicidality; Object relationship; Shame; Ester Bick.

Introduction

Suicidality presents a profound clinical and emotional challenge for psychoanalytic psychotherapists. Its presence in the therapeutic space evokes urgent existential questions, intense affective states, and often an acute threat to psychic containment—for both patient and clinician.

The Thinking Lab discussed in this article brought together an international group of psychanalytic clinicians from three continents in six online sessions of 1.5 hours each, to reflect and elaborate on such experiences.

The group noted the profound and lasting effect suicidal patients can have on therapists, persisting long after such patients have left or died. Supervision or group discussions also revived memories and feelings of existential threats and danger in past and present patients. Of note was the relative scarcity of exposure to on the subject of theories of suicide, combined with the likelihood of encountering such patients during one’s career, as well as there being very few places where clinicians felt they could discuss their difficulties with these patients.

Through mostly unpublished clinical material and group dialogue, we explored intrapsychic and interpersonal dynamics in the intersection of conflict, trauma, shame, the failure of internal holding, and the capacity (or collapse) of the therapeutic relationship. This provided a fascinating glimpse into the

profile of these patients, and how their psychopathology and suicidality were influenced by recent injuries to self-esteem and combined with past traumatic experiences.

Psychoanalytic Perspective on Suicidality

Freud initially viewed suicide as a form of aggression towards a lost or disappointing object turned inward, due to narcissistic identification with the object. He also noted the destructive power of the harsh superego. Later, he developed the concept of the death drive in which suicidal behaviour can be understood as the expression of that destructive drive to return to an inanimate state. Other views of the death drive, such as that held by C. Schmidt-Hellerau (2022), emphasise the need for release and relief of tension in the face of unbearable emotional pain. The death drive is then not seen in its destructive potential, but primarily in the function of a desperate attempt at self-preservation.

From an object relation perspective, the group thought about suicidality as a symptom and an attempt to resolve an intolerable inner conflict, often rooted in early childhood experiences. We understand object relations as a dynamic process where an individual's early experiences influence the formation of their personality, their relational patterns with others, and their own internal representations of these relationships. Participants highlighted Winnicott's concept of early environmental failure leading to lack of holding and object continuity, and its role in suicidality. There are specific dynamics connecting gender identity and its fate with internal suicidal conflicts.

The emphasis of our discussions relating to suicidality focused on injuries to self-esteem and narcissistic mortification. Deep wounds to self-esteem, triggered by certain events in human relationships, can have a significant impact on suicidal behaviour. We understand self-esteem as the confidence in one's abilities and value, and narcissistic mortification as the defensive manoeuvres put in place when that confidence is lost. The group discussed the development and stability of self-esteem, stressing how the experience of agency and object continuity in infancy forms the basis for tolerating limitations and developing a stable and realistic sense of self-esteem later in life. We explored the impact of narcissistic self-objects on identity and how their loss can trigger suicidal crises to avoid the terror of self-dissolution.

Suicidal behaviour can serve various psychological functions. It is multi-layered and rooted in intolerable internal subjective experiences and affective states. Impaired affect modulation, often stemming from early childhood experiences, can lead to intense, unmanageable feelings such as hopelessness, rage, abandonment, and anxiety. When these feelings overwhelm a person's defences, they may see suicide as a desperate solution in fantasy to escape their emotional pain.

Suicidality was understood as an attempt to resolve a crisis regressively, often triggered by recent self-esteem injuries that resonate with past traumatic experiences and with the potential to change during a patient's psychic development and treatment.

Suicidality and the Capacity to Think

The first session began with reflections on how suicidality impairs the capacity to think—both in the patient and therapist. Participants noted how suicidal states induce panic, magical thinking, and a collapse of reflective function through tunnel vision. The suicidal patient communicates that life with others is no longer tolerable—an act felt as both intimate and violent. The therapist is drawn into a shared space of desperation, evoking primal identification and magical omnipotence.

The group framed suicidality as an intrusive psychic experience that overwhelms thought and disrupts containment. The therapist may be recruited to suffer and/or metabolize unstructured affective fragments the patient cannot manage alone. This dynamic requires the therapist to suffer what the

patient cannot—an unbearable affective excess born of psychic trauma. The suicidal threat thus can be understood as an unconscious means to show and to master a desolate internal conflict situation. It is crucial to understand these, mostly projective counter transference feelings and to react in a helpful way.

Primitive Anxieties and the Boundaries of Containment

Across the cases discussed, the group's attention was drawn to the emotional impact and symbolic meanings evoked within the therapeutic settings. Participants reflected on how suicidal states can intrude violently into psychic and relational spaces, overwhelming both patient and therapist, and how this intrusion often mirrors a desperate search for containment when internal structures fail. They remarked that suicidal patients lack an "internal sustaining object" (Bick, 1968), which can lead to a desperate search for containment within the therapist's body and mind.

The discussions emphasised the regressive, bodily dimensions of such encounter - how primitive dependency and fragmentation can permeate the analytic frame and test its capacity to hold. Countertransference responses of fear, irritation, tenderness, and helplessness were examined as vital indicators of the patient's internal world and as opening the door to shared enactments of intrusion or rejection. Conversations highlighted the themes of psychic intrusion, boundary collapse, and the need for a holding environment that can tolerate intense projections of despair, shame, and dependency.

Members reflected on how the group itself functioned as a containing structure for these primitive anxieties.

Shame, and the Limits of Holding

The theme of unbearable shame emerged as a central dynamic, often manifesting as a barrier when authentic contact or understanding becomes possible, suggesting that for some suicidal patients, being seen and remembered may threaten psychic survival as much as being abandoned. The group explored the hypothesis that for some suicidal patients, shame is so psychically disorganizing that only the destruction of the self can end it. This shame, rooted in the imagined eyes of a critical other, leads to psychic fragmentation and an implosion of self-esteem. The suicidal patient mind's collapses under the strain of contact and they cannot find a safe retreat, seeing the annihilation of the body as the solution to escape the gaze of a condemning internal object. Menninger's triad of suicidal wishes (Menninger 1933)—to die, to kill, and to be killed—was quoted as operative in that context.

In tracing these reactions, the group grappled with the limits of therapeutic containment and the tension between bearing witness to destructiveness and preserving the capacity for thought.

Between Neutrality and Involvement: Theoretical and Ethical Tensions

A recurring theme throughout the Thinking Lab was the therapist's stance: how to maintain analytic neutrality while not abandoning the patient in a moment of psychic emergency. Some participants provocatively suggested that therapists must "allow" the possibility of suicide without condoning it, acknowledging its psychic reality while maintaining therapeutic containment. The group emphasized the difference between accepting suicidality as a psychic fact versus allowing suicidal action.

Participants raised the question of whether neutrality was even possible with suicidal patients. The intense affective charge and potential for enactment inevitably draw the therapist into a deeply involved position, challenging the classical analytic third.

A participant mentioned a tragic case where a patient's suicide may have been influenced by perceived rejection during therapy sessions. The group highlighted the challenges of treating suicidal patients, including the potential for enactments where the therapist may be drawn into the patient's suicidal dynamics, referring to this as the "hidden executioner" concept (Asch 1980).

The group acknowledged the impossibility of not being affected, and the risk of losing therapeutic perspective in moments of crisis.

Reflections and Theoretical Integration

Mark Goldblatt et al' s accompanying paper (2015) framed these clinical discussions within a broader psychoanalytic understanding of adolescent suicidality. Drawing on cases of suicidal adolescents, it focused on the therapeutic relationship as the primary vehicle for psychic change. The paper highlights the centrality of countertransference shame, institutional avoidance, and the therapist's struggle to engage with destructive patients while holding onto hope.

Adolescent suicidality, Mark Goldblatt argues, often emerges in response to unbearable developmental demands, especially those involving separation, bodily identity, and oedipal dynamics. Suicide may serve as both attack and defence—a maladaptive effort to assert autonomy, manage unbearable affects, or preserve a psychic fantasy of control.

He explains that the therapist's role is to create a space for open-ended exploration of thoughts and fears, providing empathic understanding and validation. The collaborative therapeutic relationship, even when disrupted or prematurely terminated, provides the patient with the experience of being taken seriously. We concluded that even if treatment ends in suicide, the quality of the therapeutic encounter remains a crucial factor in the patient's psychic history.

Conclusion: To Be With, or To Withstand

The Thinking Lab illuminated the complex intersubjective terrain of working with suicidal patients. These clinical encounters are marked by desperation, intrusion, and affective flooding—but also moments of connection, transformation, and hope. The therapist becomes a container, a target, and sometimes, a lifeline.

Through shared reflection, the group confronted not only the patient's trauma and shame but also their own—bearing witness to the depth of psychic suffering while holding onto the possibility of meaning. In suicidality, the boundary between life and death, self and other, help and harm, becomes blurred. What emerges is the necessity of a therapeutic stance that is neither neutral nor engulfed, but responsive, human, and aware.

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