

# Traumatic Subjective Experiences Invite Suicide

John T. Maltzberger, Mark J. Goldblatt, Elsa Ronningstam,  
Igor Weinberg, and Mark Schechter

*Abstract:* The overwhelming events that lead to posttraumatic stress disorders and similar states are commonly understood to arise from noxious external events. It is however the unmasterable subjective experiences such events provoke that injure the mind and ultimately the brain. Further, traumatic overarousal may arise from inner affective deluge with minimal external stimulation. Affects that promote suicide when sufficiently intense are reviewed; we propose that suicidal crises are often marked by repetitions (flashbacks) of these affects as they were originally endured in past traumatic experiences. Further, recurrent overwhelming suicidal states may retraumatize patients (patients who survive suicide attempts survive attempted murders, albeit at their own hands). We propose that repeated affective traumatization by unendurable crises corrodes the capacity for hope and erodes the ability to make and maintain loving attachments.

What pernicious qualities must an experience have to engender post-traumatic stress disorders (PTSD) and other dissociated states? While ordinarily one thinks of traumatic experiences as arising from patients' outer worlds—wars, accidents, fires, floods—the essence of traumatic experience is not overwhelming sensory stimulation itself, but rather, the failure of the mind to master the mental events the outer world gives rise to, and to the emotional commotion they arouse. Mental trauma can only happen to conscious patients. An anesthetized patient cannot be psychically traumatized. We suggest that trauma further requires a crushing affective (subjective) experience that accompanies the causative insult while the patient is helpless to escape it.

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John T. Maltzberger, M.D., Mark J. Goldblatt, M.D., Elsa Ronningstam, Ph.D., and Igor Weinberg, Ph.D., McLean Hospital and the Harvard Medical School Department of Psychiatry, Belmont, Massachusetts; Mark Schechter, M.D., North Shore Mental Health Center, Salem, MA, and the Harvard Medical School Department of Psychiatry.

Journal of The American Academy of Psychoanalysis and Dynamic Psychiatry, 39(4) 671–694, 2011  
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The thrust of the argument to be presented here is this: that the experiences giving rise to posttraumatic pathology are primarily mental. Assuredly the harmful mental experiences that concern us here may be triggered by exterior events, but what happens within the mind is what does harm.

We shall further argue that traumatizing experiences sometimes arise from within the mind, and not from shocking events in the outer world only. The sudden irruption of a terrifying psychotic state, for instance, can traumatize by its overwhelming, unmasterable emotional force. Many of the intolerable affective floods that drive patients to attempt suicide in order to escape them constitute traumata as well. Bear in mind that the person who survives a suicide attempt has escaped attempted murder.

A violent event will traumatize some but not others. The capacity to endure overwhelming suffering without sustaining traumatic injury must be determined by genetic and probably by developmental factors, but detailed understanding of this fact has not been worked out. For the most part the contemporary literature on suicide risk assessment attends to exterior events, and presumes that the experience of childhood abuse, for instance, will be the same for everyone, neglecting an important clinical fact: what induces trauma is overstimulation beyond the capacity of one's endurance, and endurance capacity varies. Only an investigation of the subjective consequences of an overwhelming event can enable the clinician to gauge how injurious it has been or may be.

## METHOD

What we present here is a theoretical essay based on the authors' extensive clinical work with suicide patients (taken together, more than 150 years). We have studied and treated many psychiatric inpatients and outpatients among whom many serious suicide attempts took place, and some suicides as well. We have also studied the literature. In an effort to synthesize what little is known about suicidal subjective experiences with contemporary understanding of traumatic experiences, psychosis, repetition compulsion, and suicidal breakup, we have cast a wide net and produced a discursive article.

Good empirical studies of the subjective states in suicide are very scarce. Perforce, we have relied on inference and inductive reasoning to support our argument. Our assertions appear probable to us, but not apodictic.

## INFERENCES

Clinically, traumatic states, when the maximum capacity of the ego is exceeded and the mind is deluged with unmanageable feeling, have several grave consequences. Regression can occur when self organization gives way and the mind breaks up (Baumeister, 1990; Maltzberger, 2004).

- (1) Not exterior events only but inner subjective experiences also can prove too much to endure and give rise to psychic trauma. Such traumata can call the repetition compulsion into play. Lasting mental injury can result from these states, leading to acute and to posttraumatic state disorder (PTSD). This assertion is supported by the psychopathological literature since before the First World War, although it attends primarily to externally provoked psychic trauma.
- (2) Traumatization of this kind can compromise patients' capacity to tolerate future crises of mental pain. The suicide literature shows repeated suicide attempts increase the probability of ultimate death by suicide (Kerkhof, 2000). Attempting suicide may become fixed as a learned pattern; after self-harm mental pain usually diminishes, so that self-destructive action can become established (in behaviorist terms) as a contingent response (Michel, 2011). Van Orden and colleagues (2008, 2010) propose that suicide practice, repeatedly attempting but failing, lowers the inhibitory threshold for future suicidal behavior because patients become less afraid of it and grow inured to the pain of it. Their theory, reckoning on the effects of conditioning and exposure to suffering, does not refer to the inner, subjective experiences of patients, and to their object and self-attachments.
- (3) Trauma is cumulative and as it builds up renders patients more vulnerable to further crises. Flashbacks of intolerable affects initially associated to traumatic moments may, when repeated across time, erode the capacity to keep up hope in the face of adversity, and weaken the capacity to make and to maintain strong attachments to others. Consistent with this proposition is Maris's (1981) proposed pattern of the "suicidal career." He infers, as do we, from our clinical experience, that repeated painful experiences lead to increasing unhappiness and depression, implying that holding on to hope, as well as to attachments to others that have a life-preservative effect, becomes increasingly difficult.

Detailed serial investigation of the affective experiences of a significant sample of patients abused in childhood has never been done, and we have no nomothetic studies about the matter. The subjective experiences of suicidal PTSD patients have not been well studied. Panagioti, Gooding, and Tarrier (2009) have reviewed this literature and remark that feelings of entrapment, defeat, and hopelessness so intimately associated with death by suicide have been egregiously underinvestigated. Careful study of the subjective experiences of suicidal patients is also work that is just now commencing (Hendin, Maltzberger, & Szanto, 2007).

### THE EVOLUTION OF PSYCHOANALYTIC THOUGHT RESPECTING AFFECTIVE TRAUMATIZATION

Freud described "signal anxiety" as a helpful adaptive device through which the self receives an alerting subjective warning that a situation of potential danger (energy overload) is arising, enabling it to take protective measures. Should protective measures prove ineffective, the signal would not go away, but increase in intensity. Signal anxiety of rising intensity may be experienced in the mid-range of subjective experience—as fear, perhaps, but rising toward panic if self-protective action fails. Anxiety of this kind may signal perceived dangers from without, frights of the sort that waking up from a deep sleep and discovering fire in the room might prompt. But anxiety of the same intensity may be aroused by dangers from within, as in the dread accompanying the sudden efflorescence of psychosis.

Beyond signal anxiety Freud described *traumatic anxiety*. He proposed that some states of psychic excitement were greater than the mental apparatus could master. A traumatic situation, said he, is one where affective excitation exceeds the mind's capacity to master it. This overexcitation he called "traumatic anxiety." In states of traumatic anxiety, the psychic apparatus will be damaged unless relief comes to hand (Freud, 1926).

Freud's word was *Angst*, a term of perhaps more general meaning in German than the usual English translation to *anxiety* implies. For purposes of this essay, we are expanding the original Freudian meaning of "Angst" somewhat to encompass a variety of painful emotional experiences too intense to endure. Any painful emotions experienced in such extremes as we address here become experiences of *anguish*.

In the study of suicide the borderland between intense signal anxiety and traumatic anxiety especially concerns us. Intense fright, terror, or

even panic to the extent that the self can take measures to escape danger need not be traumatic if the danger can be mastered. What engage us are those states of intense painful arousal when no escape is possible—states of desperation when the self is helplessly trapped.

The affect that immediately augurs passing over the line from the endurable to the intolerable is desperate anguish. Once over the line and into traumatic flooding, patients report feelings of horror, or *annihilation anxiety*, the agony of the self breaking into pieces. Annihilation anxiety is the affect of the disintegrating self (Hurvitch, 1989; Winnicott, 1974). This affect has been discussed more as a theoretical construct in the professional literature than it has been described as a phenomenon, but it is subjectively gruesome, something to be endured passively and helplessly if at all.

Standing in front of the elevators at her hospital, a 35-year-old highly qualified surgeon was seized with terror as she felt the core of her thorax turn to shattering, shaking ice. She felt she was disintegrating and dying. She fell down onto the floor before a crowd of colleagues and patients. Should such a thing ever recur, said she, she would kill herself on the spot to avoid it.

Patients that survive annihilation anxiety describe it as horrible—beyond unbearable. Reflect that *The Oxford English Dictionary* defines “horror” as “a painful emotion compounded of loathing and fear; a shuddering with terror and repugnance; strong aversion mingled with dread.”

Koukopolous and Koukopolous (1999) have drawn attention to agitated, anguished suffering in a variety of different types of Kraepelinian “mixed states” well known frequently to end in suicide.

### THE CAPACITY, OR LACK OF IT, TO BEAR INTENSE AFFECT

How the brain functions to organize the continuous afferent flood of sensory data pouring inward, allowing some to come to attention, relegating others to the periphery of awareness, is an old neurophysiologic question. How affects are regulated is a parallel question. How is it that affects are damped down, amplified, or otherwise regulated in the course of conscious experience?

This question of affect regulation bears immediately on traumatic, desperate emotional situations. This problem concerned Freud who invented the term “stimulus barrier” and referred also to a “protective shield” (Freud, 1916-1917, 1920). With these metaphorical descriptions

he imagined a mental "structure" like a skin or filtering membrane, denoting dependable neural operations too complex to be understood in the light of the neurophysiology of the day (or today).

More recent theorists, influenced by the work of Bion (1967), speak of a mental "container" that protects the self from affective flooding. The "flashback" experience is ascribed to deficient container function. Breakdown of the container leads to automatic, traumatic anxiety. Garland, elaborating the containment metaphor, helpfully directs attention to child development (Garland, 1998, p. 110). Most theorists today would agree that the capacity to regulate affect is not only genetic, but is to a considerable extent learned, and that it is contingent on the mother's having sufficient ability to tolerate and manage her infant's anxiety as well as her own. Satisfactory developmental experiences leading to internalization of soothing, self-regulating functions have been brilliantly discussed by Tolpin (1971). Furthermore, more recent epigenetic studies are consistent with the view that phenotypic expression capacity for affect regulation is influenced by childhood trauma (Brent & Mehlum, 2008; Carballo, Harkavy-Friedman, Burke, Sher, et al., 2008; Currier & Mann, 2008).

The classic papers of Elizabeth Zetzel on the mastery of anxiety and depression rely less on structural analogies and go straight to the developmental questions. The capacities to bear and regulate anxiety and depression she sees as lifelong developmental processes, subject to challenges, regressive dangers, and the possibilities of reworking and mastery across the life cycle. Her discussion of the ability to tolerate helplessness, the importance of accepting one's limitations, the capacity for good reality testing, and acceptance that suffering is inevitable and, when beyond remedy, must be passively endured, bear immediately on our understanding of the desperate affect states that drive suicide (Zetzel, 1949, 1965).

As we have seen, much discussion concerning the ability to endure intense affective suffering without mental breakdown has rested on physical metaphors such as protective barriers, shields, and containers. Traumatic events have been said to occur when these devices are pierced, breached, or broken down as armor or dams might be. Contemporary students of trauma, acknowledging that the mind may be damaged by too much pain endured too long in conditions of entrapment, are more likely to explain the capacity to endure suffering without permanent mental damage as the consequence of identification with good objects (models of endurance, resilience, and loving constancy) over the course of development, from early childhood onward, supported by the necessary constitutional (genetic) capacities.

### AFFECTIVE TRAUMATIZATION AND "MENTAL DECONSTRUCTION"

We now struggle with a staggering mass of literature concerning the mental effects of trauma. The usual traumatic sequelae afflicting the susceptible include hyperarousal, disturbed information processing, affective disturbances including anxiety and depression, disturbances of consciousness including dissociation, "flashbacks," nightmares, and other sleep disturbances (van der Kolk & Saporta, 1991). More recently we have papers linking PTSD and suicidal behavior (Panagioti, Gooding, & Tarrier, 2009; Sher, 2008). Further studies have shown that traumatic abuse in childhood, both sexual and physical, is associated with increased suicidality in adulthood (Carballo et al., 2008; Horesh, Nachshoni, Wolmer, & Toren, 2009).

Little is understood about trauma vulnerability, though there is evidence that childhood traumatization predisposes to retraumatization in adulthood when injurious circumstances arise.

Most patients improve substantially after attempting suicide; depressive symptoms seem to melt away, at least for a while. Why this is the case we do not know. However, in the hours and days that *precede* a suicide attempt, many patients exhibit symptoms like those in stress disorders. In attempted suicide the symptoms gradually appear and crescendo over days or weeks, but commonly end abruptly following a failed attempt.

This suggests that to the extent a suicide crisis is traumatic, mental injury does not so much arise from the climactic physical injury at the denouement of a suicide episode (an attempt), but rather from the accumulating helpless suffering with which patients are trapped beforehand, suffering which crescendos until it can be endured no longer. Before they attempt to kill themselves to escape it, they may be fairly compared to trench-bound soldiers under fire, in mounting danger of death, breaking away when they can endure it no more. In the First World War, panicking soldiers under bombardment, caught in trenches, would, from time to time, jump into the line of fire and try to run away. Attempted suicide may be compared to deadly flights of this kind (Hendin, Maltzberger, & Szanto, 2007).

Baumeister's description of "mental deconstruction" in suicidal crises suggests some though not all of the disrupted thinking encountered in stress disorders, *viz.*, a constriction and narrowing of time perspective, concrete "tunnel vision" thinking, and disturbance in action-planning so that proximal rather than distal goals are likely to govern decisions (Baumeister, 1990). Executive functions are compromised

in deconstructed states. Similarly, Maltzberger's (2004) description of self-breakup and ego regression in suicidal states, emphasizing affective more than cognitive phenomena, has much in common with stress experiences resulting in traumatic disorders.

"Deconstructed" states of consciousness were anticipated by Breuer and Freud, who referred to "hypnoid states." They proposed that in such states, the ordinary processes of psychic mastery could not take place, in part because affect and memory were split apart. They presumed that memory of painful hypnoid state experiences was repressed, forming the roots of future mental symptoms when repressed memories threatened to break through into consciousness. They specifically wrote that, among other causes, hypnoid states could be brought on by emotional shock, including fear (Breuer & Freud, 1893-1895, see especially p. 215). The implications for child development of traumatically induced affect states continue to be of psychoanalytic interest (Tuch, 1999). Freud never lost his interest in mental trauma, ultimately taking the view that when the mind is overwhelmed by affects breaking through mental structures inadequate for their regulation, annihilation experiences resulted. He compared these annihilation moments to childhood experiences of maternal abandonment, leading to the lasting mental injuries that underlie the "repetition compulsion" (Hurvich, 2003).

#### TRAUMATIC AFFECTS OF SUICIDAL CRISES

The emotional experiences of most true suicide crises are so painful they often defy description. Those moments just before suicidal action, and the moments immediately afterward, should a patient survive a deadly attempt, have not been well studied. They can be distinguished clinically, *but only by reference to what patients experience subjectively*. The principle subjective phenomena that concern us here are affective, and they cannot always be recognized by observation of patients' general appearance and behavior. We must rely on what patients tell us about their inner selves, the selves we cannot see but only hear about second-hand. While we wait for empirical studies of the moments immediately preceding deadly suicide attempts, we must be content with clinical descriptions that point the way for further research.

Jaspers was daunted by the challenge of studying and classifying feelings scientifically (1963). Nevertheless, it is a task not to be shirked, given the fact that subjective affect states—feelings—are now well known to underlie most suicidal behavior. When subjective distress rises to the intolerable level, when patients grow desperate for relief because they can no longer endure what they suffer, certain feelings are



commonly implicated: *hopelessness, anxiety, feeling abandoned, loneliness, self-hatred, and rage* (Hendin, Maltzberger, & Szanto, 2007). These feelings mark the moments just before crossover into the zone of suicidal action. Because detailed *affective* examination of patients at risk for suicide is so often neglected, it is worthwhile to consider what these terms mean clinically.

### Desperation, Hopelessness, and Despair

Although *desperation* sometimes has denoted the abandonment of hope, it more commonly refers to “a state of mind in which, on account of the [comparative] hopelessness or extremely small chance of success, one is ready to do any violent or extravagant action, regardless of risks or consequences” (Oxford English Dictionary, 1989). *Desperation* is clearly closely related to *hopelessness*, and even more closely to *despair* (Bürky, 2008). Etymologically desperation comes down to us from the Latin *desperare*, which in fact means the surrendering of hope. In contemporary clinical use, and explicitly in this essay, *desperation* refers to that feeling state that *stops just short* of total despair. A desperate person has not completely given up on himself, but has almost done so, and, like someone drowning, is ready to try anything to get away—he is at the brink.

In the strictest sense *despair* (total and complete *hopelessness*) is not a pure affect. If it is an affect, it is a complex one, because implicit in the term is a judgment that one forms about the circumstances in which one finds oneself. A despairing patient concludes that the present situation is intolerable, and that there is no way in this world out of it. Despairing patients are ready to try anything, including magic escapes. Intolerable affect states disturb cognitive abilities—these patients cannot “think straight.” Many suicide attempts are no more than magical gesticulations rooted in delusive fantasy that in dying one can be carried away to a better place (Maltzberger, 2004). The affect in despair is therefore total *helplessness*. The second conclusion is cognitive: if one judges there is no escape and decides to hope no more, desperation becomes *despair*.

Recent cognitive theorists have redirected attention to the importance of inescapable entrapment (a cognitive judgment) in the face of intolerable emotional arousal (an affect state), essentially concurring with Freud on the matter of giving up on oneself when trapped in excruciating and inescapable pain (Williams, Crane, Barnhoffer, & Dugan, 2005). Edward Bibring (1953) elaborated this theme, placing the despair that

arises from helplessness in the face of affective torment at the heart of depressive states.

A moment's reflection reminds us that many patients helplessly suffer *moderately* painful subjective states for long periods of time, and that they may feel to some degree hopeless about getting better. Yet most of them do not become suicidal; most of them do not despair.

A 42-year-old teacher, the father of four children, was married to a discontented wife. He was moderately depressed and quite hopeless about the future of his marriage. He confided to a friend that it was only a matter of time—a few months, a year or so—before his wife decided to break up their home and divorce him. He sadly carried on however and was never suicidal, even when his prophecy proved correct.

In this example, the teacher felt hopeless about any possibility to alter the course of his marriage, but that circumstance alone did not throw him into affective turmoil.

Many discouraged patients score well into the hopeless range on the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974). Ordinarily they can bear some level of depressive suffering without giving up on themselves. The inference is that hopelessness just short of despair is an insufficient cause for suicide, a supposition that would account for the fact that hopelessness is a better long-term predictor of suicide than a short-term one (Fawcett, Scheftner, Clark, Hedeker, Gibbons, & Coryell, 1987). Patients can tolerate feeling hopeless for a long time. An argument may be made that when hopelessness rises to the level of despair, it may then prove a necessary but probably insufficient cause for suicide. Something else is needed—anguish, or intolerable mental pain—which will then push the hopeless patient over the threshold.

### **Anxiety**

In milder forms we understand "feeling anxious" to mean feeling uneasy, apprehensive, distressed. The word *anxiety* is used to describe inner states and is sometimes contrasted with *fear*, which usually connotes some real or specific peril, perceived as arising from the outer world and not from within the self. This distinction is not always made, however, and the definition of *fear* is often extended to encompass a wider range of meaning. We see patients who are uneasy, others who are afraid of what is happening to them, others who move along the continuum further and experience terror and panic. When patients are

overcome by terror and can bear it no longer, they may despair. When despair is coupled to overwhelming terror the self begins to break apart. In such a calamity the patient experiences annihilation anxiety, a feeling akin to horror.

Panic denotes an overwhelming fright, or terror, most typically a feeling that appears suddenly. It differs slightly from terror because panic is often (but not always) accompanied by frantic efforts to escape from danger, so that the word connotes urgent preparation for action (the motor apparatus is becoming engaged, like the cocking of a pistol). Sometimes panic is directly synonymous with terror because patients may become "paralyzed" with fright and prove incapable of any action at all.

Some of Edgar Allen Poe's (1944) stories portray annihilation anxiety. In "The Pit and the Pendulum" a helpless man is trapped between four contracting red-hot walls that edge him inexorably into a pit filled with rats. In "The Descent into the Maelström" another is swallowed up by a giant whirlpool. Another is walled up alive ("The Cask of Amontillado").

The inner experience of many patients about to commit suicide belongs to anxious suffering of this level, even though the danger arises from within, and it is in the mind, but sometimes in the body also, that one burns with pain and writhes with agitation.

The wife of a 38-year-old lawyer abruptly left him and took their children with her. The lawyer felt overwhelmed; he could not sleep and found himself so agitated that at dawn he ran outside in his nightclothes, circling around and around the house in the dew, weeping and wringing his hands. The next night he dreamed of a dog trapped in a house on fire. The howling dog, covered with flames, escaped and plunged into a lake.

### **Feeling Abandoned, Loneliness**

To feel abandoned is to feel deserted, forsaken by others. *Loneliness* as an affect stops somewhere short of feeling forsaken. It does not imply permanent solitude, but rather a temporary state likely to be remedied in time. *To feel abandoned* is more nearly synonymous with *aleness* or *desolation*. *Aleness* implies total isolation from and loss of all others. It connotes a sense that the experience is forever, that it is eternal and timeless. Intense, painful *aleness* is a feeling of inner emptiness accompanied by increasing panic; patients subject to it may, over time, develop a concomitant hopelessness that tends toward despair. Though its appearance in borderline patients has received particular attention,

this affect plagues other patients as well—those who have not developed ego capacities for object constancy and who have not mastered the challenges of separation adequately (Adler & Buie, 1979).

Of course it comes as no surprise that patients' subjective sense of being connected to others is protective against suicide. Clinicians are well accustomed to asking patients whom they love, and whom they love. Engagement with others is a known anti-suicidal force in clinical work. By the same token we recognize statements such as, "Yes, my family loves me, and I love them, but they would be better off without me," as ominous. A patient who says that tells us that in his mind he is estranged from their love. Under the influence of depressive affect, those vulnerable to suicide tend not to feel the caring of sustaining relationships, to let go of them. Inability to feel and hold on to loving exterior supports devastates and desolates such patients. It is obvious, therefore, that when potentially suicidal patients' capacity to hold on to exterior sustaining relationships is compromised—when their capacity for maintaining attachments fails—they will feel more alone and their peril will increase, as they move from the experience of *loneliness* into *aleness*.

*Aleness* has a deeper meaning than feeling bereft of relationships in the outer world. (Surrounding many patients feeling "alone" in this way may be many loving family and friends, but subjectively, the patients cannot feel their care and cannot make use of it.) The desolation of *aleness* implies failure of inner resources (positive introjects, or "internal objects") that ordinarily sustain a positive affective attitude toward oneself. In other words, positive introjects (internalized good relationships from the past) are essential for maintaining good narcissistic balance. When these are deficient, as so often they are in suicide vulnerable patients, current external relationships must be relied on for keeping up a positive self-attitude. Dependency of this order chains patients to supportive others if they are to escape abandonment, *aleness* crises.<sup>1</sup> But it is not only outer relationships that may be lost or abandoned. Good inner objects may be lost or broken up as well.

In the ego-regressive processes of suicidal breakdown the mental representations of vital sustaining inner objects may be blocked off or destroyed, an event that effectively casts the self away into desolation.

Small children must depend on their mothers to protect them from external dangers, but also to protect them from inner dangers aroused by being left alone and helpless. Before a child develops capacity for

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1. Emotionally dependent patients of this kind have sometimes been called "love addicts," because loss of sustaining outside supports can throw them into agitated depressions that superficially resemble withdrawal states.

object constancy, separation from the mother may give rise to signs of overwhelming helplessness and ego disorganization (Adler & Buie, 1979). Without object and self-constancy, abandonment feelings cannot be managed in the absence of a soothing external sustaining object. Separation anxiety can overwhelm a child who has not yet developed internalizations to master it (Hurvich, 1989). Later in life, during suicide crises, when soothing internal introjects are unreachable or destroyed, experiences of aloneness repeat early separation terrors.

### **Worthlessness, Self-Hate, and Guilt**

Self-hatred should be distinguished from low self-esteem. There is a difference between feeling one is paltry, inconsequential, or even a worthless person, and hating oneself.

To feel worthless is to feel inferior to some standard of comparison, to be of no value. A worthless person is unimportant, but not necessarily contemptible. Feeling worthless is closer to feeling ashamed, beneath notice, than it is to feeling guilty.

Regrettably contemporary nosology conflates feelings of worthlessness with guilt (*DSM-IV-TR*, 2000, see criterion A7; Van Orden, Witte, Cukrowicz, Braithwaite et al., 2010). Feeling worthless need not mean one feels culpable. Guilt implies self-blame, and often enough, it connotes some more or less specific failure that merits condemnation. To be guilty is to be bad, to be worthless is to be not good (“no-good”).

A worthless person, responding to the judgment of others, might feel the withdrawal of their love or regard. But while others might turn away from a “worthless” person, it does not follow that they necessarily would hate him or wish to punish him, they might simply lose interest and care for him no more.

Guilty, culpable persons invite the ire of others—in the first place, they invite punishment. Guilt calls aggression into play, and the aggression aroused often has a sadistic color. Guilty persons can become the object of others’ malice—others may want to cause the guilty to suffer, mentally and physically. Society makes the guilty objects of aversion as well. Being “sent away” or banishment to a remote prison high in the mountains of Colorado is the fate of many major criminals.

Malice and aversion, the two subtypes of hate, are often directed at someone from without. But they may also be turned against the self from within. A person feeling guilty is hostile toward himself, and, if the guilt is sufficiently intense, he may become the object of self-aversion and malicious self-attack. Self-aversion can force suicide. Sometimes self-directed malice drives physical mutilation.

Worthlessness, therefore, implies the risk of withdrawal and abandonment by others, and the possibility of loneliness and aloneness. If the risk of being cast away as worthless is great enough, fear must be aroused. But if the feeling is guilt, punishment and retribution are implied, and one will fear what is to come.

Clinically, subjective worthlessness is often implied when patients no longer bother to look after themselves, to protect themselves from heat or cold, to bathe, to eat or to drink. Such a state of affairs is common enough in retarded depressions. Such patients lack the inner resources to care about themselves—their positive introjects, to the extent that they are present, seem out of reach or paralyzed.

Profoundly guilty patients, on the other hand, may feel they deserve severe punishments, and even beg for them. Such is sometimes the case in melancholia. If the hostility against themselves is projected outward, delusions of (seemingly deserved) persecution may appear, accompanied by subjective states of terror and panic.

### **Rage**

Rage turned out against others can also drive suicide, in contrast to rage turned against the self. Here we do not refer to repressed rage, but to rage consciously experienced. Rage at others, or at outward circumstances, often bespeaks righteous indignation. When enraged patients commit suicide, it would appear that sometimes they aim to destroy an inner object, represented by some object representation that exists in the mind. Others may aim to destroy themselves in the perception that in doing so they will kill the most precious possession of the person at whom the rage is directed. These are so-called "spite suicides" (Meninger, 1933; Zilboorg, 1936).

Phyllis, a 19-year-old university student, was unfairly reproached by her mother for a low examination grade. Phyllis grew enraged, paused long enough to leave a message for her mother she was going to rejoin her dead, always kinder grandmother, boarded a bus, and within 15 minutes had swallowed a drug overdose.

These patients' suicidal actions are almost always impulsive and differ from the classical suicides of melancholia (Freud, 1915a) in that the rage turned against the self is not subjectively experienced as depression but as fury directed outward. Rage suicides like these remind us of patients who, exploding in anger, leap from a chair and rush out of the room slamming the door behind them.

### REPETITION COMPULSION

The result of traumatic affective experiences is mental injury with perduring memories of the event, not sensory only, but affective ones also. When such memories are laid down in deconstructed states, however, they are typically ill-organized, fragmentary, and unintegrated. They are formed when the ordinary defensive operations of the ego are impaired and their repression is at best partial and incomplete. Repressed traumatic memories tend to break through into awareness, sometimes with full intensity so that the injurious event seems to be happening all over again (Garland, 1998). They reassert themselves in dreams, they drive acting-out, and do so repeatedly. Freud remarked that ". . . a thing which has not been understood inevitably reappears; like an unlaidd ghost, it cannot rest until the mystery has been solved and spell broken" (1915b, p. 146).

Much of what Phyllis Greenacre wrote about traumatization in childhood also applies to adult traumatization. She argues, following Freud, that in severe trauma the ordinary adult defensive system is knocked out of action, sometimes permanently, sometimes temporarily, so that regression to a more nearly primitive "biological" defense state occurs. Traumatic affect deluge is experienced as life-threatening and has the quality of an attack coming from without. It disrupts and disorganizes perceptual processing and the formation of normal memory. The mind must accommodate to the state of shock, to subjective defenselessness, and a new balance must be struck, in which pain and suffering come to be expected as the usual color of living. In time there may be recovery to the pre-traumatic operation of the ego-defenses, but the traumatic patterning at the deeply primitive level—the "biological level"—is not obliterated and may be aroused again throughout life. Freud called the force of the repetition compulsion "demonic." Greenacre (1967) wrote,

Put in other words, *the demon of masochism may sleep but is not slain*. In addition, the recovery in such states is only maintained at the expense of a particularly tenacious and primitive defensive denial and the utilization of an increase in primitive narcissism, both of which have deep biological roots. (p. 151)

The idea of "biological" or body memory of trauma would appear to be more than a metaphor. Van der Kolk (1994) remarks that "the body keeps the score" after trauma (p. 253). The failure of declarative memory in PTSD may lead to organization at the somatosensory level outside the hippocampally mediated memory system. PTSD patients are unable to integrate their traumatic experiences and tend instead "to

continuously relieve [sic] the past—a phenomenon mirrored physiologically and hormonally in the misinterpretation of innocuous stimuli as potential threats.” Further, traumatization, especially in childhood, has lasting epigenetic effects.

Before her psychoanalytic training, during extensive inpatient psychiatric work, Greenacre (1967) had the opportunity to study many psychotic and other deeply disturbed patients (Harley & Weil, 1990). She encountered several whose acute profound regressions were marked by florid primitive projections and dissociations triggered by what appeared to be insignificant stimuli that harked back to and connected with early life traumata.

She anticipated, therefore, recent studies suggesting childhood trauma predisposes to the development of PTSD when adult retraumatization occurs (Sher, 2008). Furthermore, recent reports show that abuse in childhood increases the likelihood of attempted suicide in PTSD patients (Krysinska & Lester, 2010).

### **CHILDHOOD ABUSE, REPETITION COMPULSION, AND LATER SUICIDE**

Childhood abuse is associated with suicide attempts in bipolar adults (McIntyre et al., 2008). More generally, childhood physical and sexual abuse are strong risk factors for the onset and persistence of suicidal behavior, during adolescence especially (Bruffaerts et al., 2010). Further, we know that the prevalence of PTSD in bipolar patients (16.0%) is double that in the general population. Both PTSD and bipolar patients report greater trauma exposure (Otto et al., 2004). In borderline personality disorder where one patient in every ten commits suicide, 81% of the patients report abuse (physical abuse, 71%; sexual abuse, 68%; Herman, Perry, & van der Kolk, 1989). This accumulation of statistical evidence inevitably raises a question: to what extent may the terrible experiences of suicidal affect in adulthood repeat earlier traumatic experiences inflicted in childhood?

### **CONCLUSION**

The following case describes the death of a patient who hanged himself while in twice a week psychotherapy. We offer it here because it illustrates points discussed in the foregoing remarks.



### **An Illustrative Case: Peter F.\***

After five attempts to kill himself, most of them serious, Peter F., a 37-year-old married man, came into treatment with a diagnosis of bipolar disorder. His attempts occurred in mixed states of desperate subjective anguish. He was seen in psychotherapy and treated psychopharmacologically for just over two years before once again he attempted suicide, this time successfully. During the period of treatment there had been no further suicidal action, but there were episodes of intense subjective suffering that were almost intolerable.

There had been multiple suicides in his immediate family. Further, between the ages of 9 and 11, Peter endured his father's raging, brutal beatings. He and his slightly older brother were screamed at, humiliated, and beaten with a belt to the point of bruising. The father would sometimes excruciatingly twist the boys' arms. Sometimes he would choke them. Once he held Peter by the shoulder out over the banister of the staircase. Once he made the boys pull down their pants and whipped them in a public parking lot. They whispered to each other that maybe he would someday miscalculate, go too far, and kill them. Anything that made the father feel the boys were being "silly" or "girlish" was likely to set off one of his rages. Anything he felt had a homosexual color threw him out of control. "Faggot" was a terrible epithet in this family.

Peter began to be depressed in high-school. He managed to do well academically and athletically but was tormented by feelings of shame in the locker room and sensitive to the sometimes humiliating criticism of the basketball coach. He went to extraordinary lengths not to let the other boys see him naked, sedulously avoiding group showers. Perfectionistic and anxious, his social life was stunted; he had few if any real friends. He said he always felt as though he were on stage, an actor trying to look good to others, afraid that with one misstep he would disgrace himself and invite their mockery. He was a miserable adolescent, deeply ashamed of his body, profoundly guilty about sexual feelings.

By the time he was 18 Peter had made his first experiments with carbon monoxide asphyxiation. Depressed as a college student, he dropped out and went to live abroad. He began to have episodes of depressive excitement, drank heavily, and threw himself into the gay scene. When 25 he took a massive overdose of acetaminophen in his second suicide attempt and recovered without medical attention, feeling sorry he had not died. Returning to the United States, he completed

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\*Names have been changed and personal clinical material in this article has been disguised.

his college studies and married, setting his homosexual life aside. He was able to work in a sustained way but continued to drink too much and to get into excited, rageful suicide states.

He made two more serious attempts in his 30s. Describing one of these attempts, he said he had been sleeping badly for some time and staying up late. "I was really jazzed up about it, feeling very indignant. What right did other people have to tell me I had to live on? It was my life," he said. He had been to a strip club and was drunk, driving recklessly, feeling very angry and very excited. "I was really pumping myself up. I felt very focused, very hyper. I was laughing in this crazy way. I rigged up the hose to the car and kept telling myself to breathe deeper, breathe deeper." He was rescued by narrow chance.

These states of agitated depressive excitement would crescendo into rages turned against himself—so intense would be his self-loathing that he would hit himself, curse himself—he said he was "rancid, fucked-up, toxic, nasty, disgusting, a pathogen," that he looked like a monster. During intense rages he wanted to demolish everything in reach. He shouted, he smashed furniture, threw the computer across the room, cursed himself, hit himself. He terrified his dogs. He said on these occasions he was like Mr. Hyde on a destructive rampage.

He would race around dangerously in his car in states of desperation and anguish that drove him to attempt suicide as an escape. At other times he described feelings of frozen emptiness, desolation, loneliness. There were spells of uncontrollable crying. He often slept badly and reported dreams the content of which he could not recall, but in which vivid painful affects of shame and humiliation repeated themselves. "I don't know what it is to have a pleasant dream," he said.

Before hanging himself Peter wrote a note describing feelings of sad, empty desolate dread continuous "every second of each day." He wrote of dread felt in the pit of his stomach, worried thoughts, bad memories, repetitive bad thoughts of self-accusation and loathing.

In the course of the psychotherapy the patient described the beatings and humiliations of his childhood. He said, "I was terrified of my father, so terrified I had to surrender all spontaneous expression, every liberty, every choice, to him. He was a tyrant, a dictator of a father." He wondered what kind of a person could so mistreat a child. Intense affect was recovered along with memories, and the patient seemed to make good progress, with appropriate abreaction, tearful and angry, without signs of dissociation, as he worked over this material.

He said that his father was a Jekyll-Hyde; outwardly an admired and respectable member of a professional community, but at home an explosive and terrifying monster. Peter called himself a Jekyll-Hyde, referring to the raging suicidal states as Mr. Hyde out of control. There

were several occasions in his later 20s when Peter, in an excited, agitated state dangerously provoked the police—he was lucky not to have been clubbed. These occasions had the quality of repetitions of the shouting, beating scenes from childhood. Many of his dreams had flashback qualities that repeated the affects of rage, entrappedness, self-loathing, and shame that he had experienced over and over during the childhood beatings.

Toward the end of his life Peter told his doctor that he did not want his wife or his friends to care too much for him; he did not think he could survive another full-blown suicidal episode and did not want to be held back from suicide if his illness recurred. He did not want to care anymore.<sup>2</sup> Profoundly discouraged, but very attached to his psychotherapist (a psychoanalyst also trained in dialectical behavioral therapy), he relied on the treatment relationship to keep up hope. Basically, without the hopefulness and dedication of the therapist, Peter could not alone trust that any kind of sustained, reasonably stable recovery was possible.

When the therapist had to interrupt the treatment to undergo a major surgical procedure telephone contact was maintained, so that the therapeutic relationship was not totally interrupted except for a period of about 12 days (there were no face-to-face meetings for a month). Just before regular face-to-face sessions were to resume, Peter secretly planned suicide over a period of several days, concealing his impending suicide from the therapist, even though they were speaking on the telephone twice weekly. He then hanged himself. In a note left behind, he made it plain he was exhausted, did not want to be impeded in his plan, and explained that what he was doing was self-euthanasia.

The genetic predisposition to suicide was very plain in Peter's case—there were many suicides in his family. Though he suffered from Bipolar I disorder, living through many mixed-state experiences, and attempting suicide repeatedly, the lasting and traumatic effects of childhood physical abuse stands out in the history. Peter described the floods of intolerable affect that marked his suicide crises as being just like those he remembered from childhood—terror, rage, abandonment, despair, self-hatred. In dreams he experienced thinly disguised flashbacks of being beaten. His flashback experiences, and the reliving of intolerable affects, had the color of posttraumatic stress disorder. They repeated themselves over and over.

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2. Conversely, another patient, recovering from a third suicide attempt, decided she was alienating her family with the attempts, and that she had to stop trying to kill herself, because her behavior was weakening her love for them, and theirs for her.

Each recurrence of the intolerably painful suicidal crises further discouraged him. Gradually he gave up hope that he could ever really escape his illness. He despaired of recovery. Aggressive psychopharmacology and assiduous twice-weekly psychotherapy were not enough. His experience with suffering was such so that he gradually surrendered hope. Furthermore, although he was lovingly attached to his wife and to his therapist, the quality and the intensity of his engagement with them was not enough to keep him alive. He explicitly said at the end that he wished others did not care, and that he wished that he did not care for them, because caring made suicide more difficult. Falling into affective torment over and over had a cumulative discouraging effect so that in the end he gave up hope. Repeated suicide crises led to his withdrawal from attachments to others as well, so that he repudiated anchors to hold him steady against the dark currents that slowly washed him away.

For the present we are limited to idiographic material such as the case of Peter F. in order to understand the subjective experiences of suicidal patients. Study of patients such as he strongly suggest that repeated attacks of traumatizing intense affects, affects sufficiently devastating as to force suicide attempts, are themselves cumulative in effect and over time corrode two necessities for sustaining oneself and living a supportable life: the capacity for making and keeping loving attachments to others, and the capacity to continue hoping in the face of recurrent adversity.

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John T. Maltzberger, M.D.  
 1010 Waltham St., Apt. H293  
 Lexington, MA 02421  
 maltsb33@verizon.net

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