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SUICIDAL BEHAVIOR

The State of the Art

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1.1.7 Psychoanalytic Psychotherapy of Depressive and Suicidal Elderly

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Introduction

In German psychiatrists' offices only one of 200 patients, over 65 years old and diagnosed as depressive, get a psychotherapy according to the guiding-principles of social insurance (Arold, Schmidt 1990).

Last year "Deutsches Ärzteblatt", the official physicians' publication, discussed the question of whether to treat suicidal old people at all, asking: "In how many cases of patients who are being "saved" after attempted suicide is it possible to really alter the internal and external conditions so that the person regains a positive attitude towards life?" This question is never asked in the context of any other problem and it means indirectly that old people should die under these conditions. What is the logic behind this attitude? Doesn't medicine normally tend to fight to the utmost in order to preserve life? In my opinion, we shy away from getting involved in the internal and external problems of the elderly, even though we will inevitably be confronted with the same problems personaly very soon. Furthermore, old suicidal and depressive patients upset the conception we have or like to have of our own elderly. We are afraid of being confronted with their aggression. This way, they attack our confidence and the narcissism we feel as good therapists. Consequently, we protect ourselves against old-age suicidals by means of various defence mechanisms, normaly they don't get any psychotherapy.

The social depreciation and isolation of the elderly will be continued if treatment is withheld for the reason of age. Their lives are being downgraded as being worthless. Indirectly, they are even being encouraged to kill themselves.

There do exist systematised methods of basic treatment of attempted suicides and even acknowledged regulations of psychiatric crisis intervention and treatment of depression, but there are no concepts and reports on experiences of psychotherapy available which consider the human relationship.

My presentation is based on the psychoanalytical theory, in particular the object-relation theory of depression and suicide. A social worker's intervention is additionaly often very important, expecially for old patients. I'm going to present a bilateral concept, which is aiming at a change of the internal and external conditions.

The psychoanalytic approach

The growing conciuosness of aggressive impulses represents a problem when using psychotherapy in treating suicidal and depressive patients. Painful guilty feelings can be increased and suicidal tendencies can be encouraged. Beginning to focus on the insight of a specific aggression, on anger caused by narcissistic mortification, was an important inprovement in the treatment of these patients. This mortification is triggered by the loss of an object that had been selected in order to strengthen the selfesteem. The object ist not being loved for its own self, but there are certain aspects the other represents which are being assimilated as a vital part of the own self and which are in most cases being idealized. When

experiencing loss, a feeling of helplessness, haplessness and hopelessness (Osgood/Thielmann 1990) descends on the suicidal person from which he tries to escape. He tries to find his rescue in a harmonious world of oceanic bliss. This helps him to overcome his powerlessness and gives him a feeling of supreme power. Suicidals mostly do not wish real death, as has been shown by investegations into sucidal phantasies (Henseler 1974).

It follows that the feeling of selfesteem is closely tied to object relations. This relationship determinates the dynamics of old-age suicide.

With oncoming age we are being confronted increasingly with losses of objects and with the gap between the idealized and the actual selfconception.

A strong feeling of selfconfidence and accordingly object relationships put us in a position, where we can experience the indications of oncoming age and the inevitable losses without denial and without a sensation of annihilating anxiety. It is possible to mourn for losses if good internal objects convey the feeling that "one's inner resources are sufficient to continue reaffirming oneself and that one can rely on one's own abilities to reestablish a reasonable life." (Kernberg 1988, p.147)

But in the course of getting older, losses occur, which can have the implication of narcissistic mortifications and which have to be the focal point of therapy. The stress is on feeling accepted not any longer and being taken care of or on the conceptions of value, power and influence or on psychosexual identity, which in most cases will be the first to be challenged. With oncoming menopause women are forced to develop a changed attitude towards their genital sexuality. With men, this identity is frequently tied to their occupational existence. An unsettling lability of the psychosexual selfesteem possibly results in a "phallic-narcissistic crisis".

Later on, at the point of retiring from working life, with a lower income, or when the children are leaving their parents' home or when one's own parents die, the attitude towards values and power has to be redefined. This attitude is being established during the anal phase of development. Anal-narcissistic crisis are closely related to issues of values and power. Surmounting them is part of getting older, a challenge that men in particular frequently are unable to meet in our cultural framework and that only too often leads to suicidal crisis.

During the oral phase of development the feeling of security, the ability to trust and the feeling of being accepted are created. In this phase the suckling baby is completely dependent on being taken care of by his mother. Dependency on being taken care of is a trait of very young, but frequently also of very old age. The problems of locomotion and of nutrition are predominant, exactly as during the days of early childhood. In situations of actual or threatening object losses which are connected with this type of problem, "oral-narcissistic crisis" can be mobilized.

In the course of the aging progress, the narcissistic stability of different psychosexual stages is in a way evaluated. It depends on the narcissistic vulnerability of the individual developed during his childhood which of the possible narcissistic mortifications he is unable to work out. Our daily practical experiences (Wächtler 1984) show us over and over again: It is not only the real isolation, the actual state of health, the factual loss of power which is decisive, but essential are the subjective values they are freighted with, their importance for the feeling of selfesteem.

The losses of partners, of physical capacity or of social values, such as work, income and accomodation can lead to a feeling of defeat if they had possessed the quality of narcissistic objects, and can lead to limitation of the ability to decide and to act. There will be a feeling that a part of one's self has been lost or destroyed, without being aware of the chance to create a replacement, and with growing age, these chances are indeed being reduced. The suicidal element of old age is equivalent to the deeply humiliating awareness of one's inner emptiness, ob not being loved or having been loved and the lack of stable internalized object representations. It appears so much easier to remove oneself from reality, to escape into phantasies of all-embracing power, than to face the sadness and to mourn. The result is a brakdown of ego functions, a pathological regression, with a direct transformation of phantasies which the suicidal action is supposed to turn into reality. But a sucicide crisis contains a chance for further development as well.

Concept of Therapy

We have been ablo to develop our concept since 1983 for patients older than 65 years in a psychiatric ambulance as a part of a governments' programm. We could apply the concept in the framework of a psychosocial service in General Hospital by a liaison cooperation between the internal ward, social workers, psychologists and psychoanalytically trained psychiatrists. I got to know 90 old patients in suicidal crisis. 42 of them I treated by myself. 48 I got to know by our conferences as a team member.

Patients had 3 - 5 interviews as an average, in several cases there was established a longer-lasting psychotherapy of a duration up to 3 years.

As a psychotherapist, I am proceeding along the lines of a concept of treatment which Reimer and Henseler (1984) described for suicidal patients. This means taking the following steps into account:

As a rule, a "mortifying incident" will be discovered at a time which precedes the acute suicidal action immediately. This mortifying incident is conscious. The "main cause" is unconscious. The mortifying incident is directly connected with this cause. We are trying to find the "common denominator", which, seen on the background of the biography, explains the traumatic element of the actual mortification.

The common denominator is to be detected in the transferrance and countertransferrance, in this way proving the correctness of our hypothesis. That's the reason why we have to center our attention on the interaction.

I would like to demonstrate, that it is possible to help patients by menas of this concept, even if it is not possible to analyse this patient.

A case history

A woman of 72 years becomes my patient in General Hospital after an attempted suicide by means of tranquilizers. I am suprised at her appearance. On the day after the suicide attempt, she looks fresh, is made up, too heavily for my taste, and is dressed with fashionable youthfullness. She enters my office supported by a stick however, and begins at once to mention vague pains, particularly in her legs. She mentions her attacks of depression with several attempted suicides, the first one when she was 23 years old. Then she puts the brochure of a pain clinic on the table and asks me whether I might help her to be accepted there. I become aware of a touch of anger and I am asking myself why she is evasive. My first explanation is that she is possibly trying to find out whether I am going to help her in spite of the trouble she is creating right from the start.

As becomes clear later on, she also asks me, whether I shall be willing to be used by her for her own purposes, or if I am going to send her away, which would correspond to my first impulsive anger. I ask her what had happened on the day she took the pills. She had been prevented by heavy pains to take the bus in order to visit her son and his family. Telling this, there are tears in her eyes, which I cannot follow emotionally. The dynamics of the attempted suicide are not yet plausible to me. We are planning further interviews.

In the ward, the patient, who is going to be sent home as soon as possible, is conspicuous by her tendency towards prolonging her stay in hospital. She approaches the social worker incidentally, or so it seems. She is urgently awaiting her next pension payday. On the very day she took the pills, her money had not been sufficient to buy presents for her grandchildren and to pay her bus fare. When the social worker looked into her financial situation, it became obvious, that she felt ashamed and hesitated to go to the social welfare center where she, as the patient was well aware, could fightfully apply for social support. She did not want to let her financial dependency become appoarent, which was unterstandable against the background of her lifelong problems in establishing and maintaining her selfconidence.

The patient was an adopted child, "my rich mother needed me for showing off, because she was childless." She heard about her Jewish origin when she was going to get married because of her pregnancy and needed a document which confirmed her being an Aryan. Because of her Jewish origin, she felt stigmatised in the family which had adopted her. The father of her child deserted her. He paid "social support", as the patient called. Half a year after a son was born to her, she tried to poison him and herself. Her further development is characterized by physic crises. Between his 10th and 14th year, her son grows up in a children's home. The patient wants to make up for her wrongdoings, but she establishes her relationships in a way that her respective partner feels exploited immediately. Her

son says: "I'm feeling sick when I see you, you are my mother just by accident." She is fighting for being accepted by him and as the loving grandmother of his children. She transfers aspects of her relationship with her son to my person. Right from the first incidence, I am feeling exploited and manipulated, devaluated in my function: and yet she woos for my appreciation, e.g. by her way of dressing.

My understanding of the patient was such that she experienced a first severe identity crisis at the time her son was born. Her unstable selfesteem was deeply shaken by her becoming aware of her origin and by the social evaluation which to her meant a psychic extermination. Her helpless rage turned against her son and against herself. Even now she is making efforts towards a narcissistic stabilisation. To this effect she is exploiting any object reltionship, e.g. the contact through therapy.

I had 14 interviews with this patient. The pain symptoms faded into the background and the suicide tendencies were no longer acute. However, further crises have to be expected again, as soon as actual mortifying incidents appear. My efforts to interprete the transferance in a way, that would have turned into a process of insight or of changing, were not successful during this short therapy. Whenever it was attempted, the patient regarded this as attacks, reacted in a hurt way and retreated. It became obvious, that she expected an outcome from the therapy that sould represent a compensation for the inner ties her son denied her. She tried to use the therapist, as she wished to use her son, as a means to stabilize her narcissistically unstable self.

Nevertheless, subjects the patient had not been able to talk about, and which were to be transformed into direct suicidal action could be made verbalized, could be symbolized.

In our example the mortifying incident was the actual financial distress. The main cause was loss of the autonomous feeling which was of particular importance to the patient. The common denominator of the present situation and of the biography could be delineated and was apparent in the interaction fight from the initial interview.

It is important to take into account right from the beginning the narcissistic element of relationship during the therapeutic contact. We often observe, contrary to this example, an idealization of the therapist. "I could not speak to any other person as yet as I can with you." The idealization is followed by depreciation with renewed experiences of loss and suicidal risk. This is why it is helpful and necessary to point out this danger right from the start. Such as "this is certainly a great help for the therapy. However, it might happen that things might not work this way any more, and it is of importance just then that we continue talking to each other." In this case, to pave the way for a conversation, the institutional framework of the hospital, the intervention by the social worker and psychodynamic understanding were necessary.

This concept, basing on the psychoanalytical theory of narcissism has become the prevailing method in Kassels Municipal hospital since several years.

It offers a satisfying systematical psychotherapeutic approach to the elderly suicidals, who are mostly regarded unable to be treated.

However, an internsive affective relationship of patient and psychotherapist is necessary in regard on the specific aspects of transferance and countertransferance. Up to now, psychotherapists and other professionals mostly avoided this kind of therapeutic relation.