Psychotherapy Strategies and the Chronically Suicidal Patient

July 01, 1999
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The benefits of psychotherapy in treating the chronically suicidal patient, as well as strategies that can help the potential suicide patient imagine and reflect others' reactions to this most final of acts, was the subject of a conference by Glen O. Gabbard, M.D., at the 11th Annual U.S. Psychiatric & Mental Health Congress. Gabbard is the Bessie Callaway Distinguished Professor of Psychoanalysis and Education at the Karl Menninger School of Psychiatry and Mental Health Sciences.

Based on previous research and his own experiences as a psychotherapist, Gabbard has found that in some patients, especially those diagnosed with borderline personality disorder, the ability to imagine other people's feelings and reactions to their suicide is impaired.

Gabbard said that physicians should enter into their patient's suicidal fantasies instead of avoiding the subject due to clinician discomfort or the usually incorrect assumption that patients will become more suicidal as a result of an open dialogue. In turn, he commented, this will enable patients to understand the consequences of their suicide. Gabbard also recommends that physicians facilitate a detailed elaboration of the borderline patient's fantasies about what happens after the suicide is completed. "This frequently leads to a recognition that the patient is not adequately imagining the reaction of others to his or her [own] suicide," he said.

Development of Mentalization
"Part of the borderline patient's psychopathology is a kind of absorption in a very limited, narrow view of their own suffering, where the subjectivity of others is completely disregarded. They often have a very poor sense of subjectivity regarding other people," Gabbard explained. "To a large extent there is an incapacity to imagine another person's internal role or their own internal role. So they are very much out of touch with inner life."

Mentalization and reflective functions are often used in very similar ways, said Gabbard, and involve the theory of mind, which is the capacity of a person to think of things as motivated by feelings, desires and wishes. In other words, he noted, "you're not just the sum total of your brain chemistry."

"If things go well," Gabbard continued, "mentalization will develop after the age of 3. Before the age of 3, you have what's called psyche equivalence mode, where ideas and perceptions are not found to be representations, but rather accurate replicas of reality. In other words, a little kid will say, 'The way I see things is the way they are.' This child is not representing anything, it's just the way he sees it."

According to Gabbard, after the age of 3, this kind of thinking develops into the pretend mode, where the child's idea or experience is representational rather than a direct reflection of reality. He cited an example of a 5-year-old boy who says to his 7-year-old sister, "Let's play mommy and baby. You'll be the mommy and I'll be the baby." In normal development, the child knows that the 7-year-old sister is not mommy, but a representation of mom. He also knows that he's not baby, but a representation of baby, Gabbard said.

A borderline patient, on the other hand, has great difficulty with mentalizing and reflective powers, Gabbard explained. Just as the child before age 3, they are stuck developmentally, and may comment to their therapist, "You are exactly like my father." In normal development, however, Gabbard noted that "reflective functions contain both self-reflective and interpersonal components. That ideally provides the individual with a well-developed capacity to distinguish inner from outer reality, pretend mode from real mode of functioning, [and] interpersonal mental and emotional processes from interpersonal communications."

According to Gabbard, recent studies show that traumatized children who can maintain mentalization or reflective functions and process it with a neutral adult have a much better chance of
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Published on Physicians Practice (http://www.physicianspractice.com)

coming out of the trauma without serious scarring. "You always see these amazing kids who have been abused pretty thoroughly," he said, "and yet they're fairly healthy because somehow they've been able to appreciate what happened and why."

As a result, Gabbard will often ask a borderline patient, "How did you imagine that I felt when you were suicidal and didn't show up at your session?" Or, "How did you imagine I felt when I was sitting in my office wondering where you were and if you had hurt yourself?" By doing this, he said, patients can start developing fantasies about how other people think.

"If I want to get the child or adult to move from this kind of psychic equivalence mode to a pretend mode, I can't just copy the patient's internal state, I have to offer a reflection about them," said Gabbard. For instance, in his practice, Gabbard observes the patient, then tells them, "this is what I see going on." Thus, he explained, the therapist can gradually help the patient learn that mental experience involves representations that can be played with and ultimately altered. **Clarifying the Picture: A Vignette**

Gabbard illustrated this by discussing a former patient he considers one of his most difficult: a 29-year-old chronically suicidal woman who is an incest survivor with borderline personality disorder. "She was difficult," Gabbard explained, "because she would show up [to the session], and then she wouldn't want to talk. She'd only sit there and say, 'I just feel terrible about this.'"

Searching for a breakthrough, Gabbard asked the woman if she could draw what she was thinking. After being presented with a large pad of paper and colored pencils, she promptly drew herself in a cemetery, six feet underground. Gabbard then asked the woman if he could be allowed to draw something into her picture. She agreed, and he drew in the woman's 5-year-old son, standing beside the tombstone.

The patient was obviously upset and asked why he had drawn her son into the picture. "I told her because [without her son] the picture was incomplete," Gabbard said. When the patient accused him of trying to lay a guilt trip on her, he replied that all he was trying to do was get her to think realistically about what would happen if she did kill herself. "If you're going to do this," he told her, "you have to think about the consequences. And, for your 5-year-old son, this is going to be pretty much of a disaster."

Gabbard chose this approach because emerging psychological literature suggests that the capacity to mentalize results in a kind of prophylactic effect against the pathogenicity of problems. "One of the things I was trying to say to this patient by drawing her 5-year-old son into the picture was, 'Let's try to get into your son's head and think what it would be like for him to experience [your suicide].' I was trying to get her to imagine that other people have a separate subjectivity from her own."

According to Gabbard, this helps the patient gradually learn that mental experience involves representations that can be played with and ultimately altered, thereby "re-establishing a developmental process by reflecting what's going on inside the patient's head and what might be happening in other people's heads."

Two months after the session, the patient was released from the hospital and returned to her home state where she began seeing another therapist. About two years later, Gabbard ran into that clinician and asked how his former patient was doing. The therapist said that the woman was doing better and frequently made reference to the session where Gabbard had drawn her son into the picture. "She often gets very angry about this," the therapist told him. "But then, she is still alive."

Gabbard said that in his practice he tries to stress to the borderline patient that they have human connections even when they feel like nobody cares about them. "If you look at the suicidal borderline patient," he said, "almost all of them have a kind of despair, a sense of radical absence of meaning and purpose and the impossibility of human connection because they have so much difficulty in relationships. And yet many of them are more connected than they actually realize."

Unfortunately, Gabbard has seen this most often in inpatient situations where a fellow patient's suicide takes a heavy toll on the other patients. "I remember vividly a group therapy session in a hospital after a patient had killed herself," he said. "While people were sad, I was more impressed with how furious they were. They would say, 'How could she do this to us?' 'How could she leave us with this?' 'Didn't she know that we were connected with her, that we were her friends?' So there was a huge impact on the people left behind." **The Pitfalls of Rescuing**

Gabbard noted that there is a drawback in working so closely with the chronically suicidal: Through objective identification, the clinician starts to feel what a patient's family member or significant other might feel if that patient committed suicide. "Sometimes, the clinician's attempt to identify with members of the suicidal patient's family leads to increasingly zealous efforts to stop the patient from committing suicide," he added.

Gabbard cautioned clinicians about their attitudes toward treating these patients. "If you get too
overly zealous in trying to rescue the patient, you're starting to create a fantasy that you are an omnipotent, idealized, all-loving parent who's always available, but you're not," he said. "It's bound to lead to resentment, if you try to take that role. Plus, you're bound to fail, because you simply can't be available at all times."

There is also a tendency for patients to assign responsibility elsewhere for staying alive. According to Gabbard, Herbert Hendin, M.D., made the point that to allow a borderline patient's tendency to assign others this responsibility is a very lethal feature of suicidal tendencies. The clinician is then haunted by the need to keep this patient alive, he said. This, in turn, may lead to countertransference hate: the clinician may forget appointments, say or do things subtly and so forth. Such behavior may actually lead the patient to suicide.

The therapist can also act as a vehicle for understanding by containing "affects that are not tolerable to the patients," Gabbard said. "Eventually the patient sees that these affects are tolerable and they don't destroy us, so maybe they won't destroy the patient. I don't think we need to worry too much about making brilliant interpretations. I think it's more important to be there, to be durable and authentic and try to contain these feelings and survive them."

In closing, Gabbard noted that 7% to 10% of borderline patients kill themselves, and that there are terminal variant patients that do not seem to respond to anything. "We do have terminal illnesses in psychiatry just like we do in every other medical profession, and I think we have to recognize some patients are going to kill themselves despite our best efforts. [We need to] try to avoid taking on all the responsibility of that," Gabbard said. "The patient has to meet us halfway. We can only do so much, and I think accepting our limits is a very important aspect."

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