Projective identification and suicide contagion

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The effect of suggestion on suicide is well established. However, the intrapsychic mechanisms of the contagion of suicides are poorly understood. In this article I first present the literature about suicide clustering and about projective identification. In the following clinical vignette I try to understand a patient's suicidal behaviour, referring to William Goldstein's clarifying model of projective identification. I aim to illustrate that his model has heuristic value in the treatment of suicidal patients when the effect of suggestion or identification is suspected.

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The understanding of the reasons for contagion of suicides is becoming increasingly important for two reasons. First, increasing adolescent suicide rates have been documented in many industrialized countries (1) and therefore more and more young people have a relative or a friend who has committed suicide. Second, increasing inpatient suicide rates have been reported in psychiatric hospitals (2–4) and inpatients must therefore face the suicide of a fellow patient more often than before.

Most of the researches about suicide clustering have been epidemiological macro-studies, which have left the intrapsychic mechanisms open. This article briefly presents the literature about suicide contagion and summarizes the psychoanalytic concept of projective identification, referring particularly to William Goldstein's (5) clarifying model. Then I present a clinical vignette and finally try to analyse it according to Goldstein's model as a heuristic tool. The concept of projective identification may be useful when the suicidality of the patient is suspected to be effected by suggestion.

In September 1774 Johann Wolgang von Goethe published his first novel, *The sorrows of young Werther*, whose hero shot himself, unable to bear his desperate love. Many romantic young men in Europe identified themselves with the hero and subsequently the number of suicides rose dramatically. The authorities in Italy, Germany and Denmark banned the book in hopes of putting a stop to the suicide epidemic.

Emile Durkheim, who wrote the first scientific study on suicide in 1897, came to the conclusion that imitation can cause clustering of suicides: "perhaps no other phenomenon is more readily contagious" (6).

In 1974 David P. Phillips created and defined the term "Werther effect" to mean an increase in the number of suicides caused by suggestion. In his classical article, Phillips (7) used statistics from the United States and the United Kingdom to show that the number of suicides increased after a story of a suicide was published in the press. For example, after the suicide of Marilyn Monroe an increase in suicides was detected in both countries. Later studies have demonstrated that suggestion has an effect also on the method of suicide (8) and that teenagers are especially susceptible to the Werther effect (9–11).

Most studies about suicide clustering have been macro-level epidemiological population surveys. The exact mechanism of contagion has been left obscure; usually the authors refer either to imitation or to identification. There are, however, also some micro-studies about suicide epidemics in small communities. In these studies, low self-esteem, withdrawal, family conflict and internalization of feelings have been identified as risk factors for suicide contagion (12, 13). In an interesting study about self-mutilation among disturbed adolescents, Rosen et al. (14) came to the conclusion that contagion may be best understood in terms of dyadic or small-group interactions.

Suicidal behaviour in the parental home is a risk factor for suicide (15, 16) and identification with the suicidal parent has been speculated to promote suicidality (16). However, there are also many other factors than identification contributing to the suicidality of patients coming from homes with suicidal behaviour. Adoption studies provide some evidence for genetic vulnerability for suicide (17) and negative parental rearing behaviour may also increase suicidality (18).

Suicide contagion has also been documented in psychiatric hospitals (19, 20). In a study about a suicide cluster in Turku, we divided the factors contributing to contagion into 4 groups (20):

- suggestion: an inpatient begins to think of suicide as a possible solution;
- breakdown of the professional self-confidence of the staff members;
- propagation of a hopeless atmosphere in a ward; and
- psychotic identification.

The concept of projective identification may be helpful in the analysis of the fourth group. Melanie Klein (21) was the first to use the term projective identification. Segal (22) has crystallized Klein's description of projective identification as follows: "Parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts". Klein believed that the process of projective identification begins in the first three or four months of life, during so-called schizoid-paranoid position (21).

The term projective identification became popular outside the Kleinian school with the publication of Otto Kernberg's work on borderline personality organization. Kernberg listed projective identification as one of the primitive defences, and presupposed that only self-representations can be projected in projective identification proper (23). Nowadays the therm projective identification is referred to also in wider connotations. According to Ogden, the projection of object representations can be included to projective identification, which therefore becames as a normal feature of transference (24).

Goldstein (5) has recently clarified these various usages of the term by dividing it into three steps:

1) the projection of a part of oneself onto an external object;
1a) the blurring of self and object representations;
2) interpersonal interaction in which the projector actively pressures the recipient to think, feel and act in accordance with the projection; and
3) reinternalization of the projection.

Goldstein notes (5) that the different meanings of projective identification depend on which of these steps are deemed to be necessary for the definition of projective identification.

Case report

This case history is made unidentifiable by leaving some facts intentionally unmentioned (such as treatment year, age, profession, etc.), but things reported are unchanged except the name Betty, which is not the real name.

Betty was born to a farm family and she had one younger brother. Betty describes her parents as ordinary, decent people, but complains that they somehow rejected their children and that they were too frivolous. Betty recalls that when she was 4 years old she tried to commit suicide by jumping down from the garret stairs because her mother was not interested enough in her. Betty accomplished her school normally and got a middle-level professional education. She has always been lonely and never gone steady with anybody and she describes herself as inclined to melancholy. Although Betty worked in a city 230 km away from her farm home, which her brother had taken over, she visited her family every weekend.

Betty's brother was a cheerful and social man with a permanent girlfriend; Betty never noticed any marks of depression on him. When he was 35 years old he died in his car of a heart attack after having being ill for some months. His death was never discussed in the family and Betty's parents avoided talking about him.

About one year after her brother's death, Betty started to have delusions with sexual and aggressive contents. She thought that her cousin, whom she liked a lot, had assassinated Kennedy and Olof Palme. She also blamed her boss for raping and killing two hitch-hikers. She was never afraid of these men herself; on the contrary, the idea of her cousin being an international terrorist amused her in a vague way. At the same time, Betty became convinced that her brother had actually committed suicide and that her parents had kept it from her.

After contemplating these ideas for some months, Betty became sure that her brother had been extremely depressed and hopeless before his suicide, only appearing to be happy. When she realized this she started to feel herself more depressed than ever before. At this time Betty was already in psychiatric open care referred by her employer. The author met her once a week and she also had mild neuroleptic medication. Betty described that she could feel her brother's enormous agony inside herself. She was voluntarily referred to a psychiatric hospital by the author because of her suicidality.

In the hospital she took a neuroleptic overdose and the treatment continued involuntarily for some weeks. At this time Betty was described as motorically retarded, quiet, distant and extremely suicidal. Her DSM-III diagnosis was major depression with mood-incongruent psychotic features (296.34).

After leaving the hospital Betty moved to her farm home and has lived there ever since with her parents. She continued to meet the author once a week in supportive psychotherapy, which focused on the differences between Betty and her deceased brother. Two years after the suicidal crisis, Betty is still convinced that her brother committed suicide, but she

does not feel any more that her future is inevitably bound to her brother's destiny.

Discussion

Freud stated that internalization is an essential part of depression. The depressive patient internalizes the lost, narcissistically important object, trying to rescue it within himself. When this ambivalently loved internalized object becames overcathectic with aggression, the result may be suicide (25).

Freud's theory helps us to understand why the object representation of the deceased brother became so important for Betty. The death of the brother created a pressure for internalization in the depressive patient. Internalization resulted in the blurring of self and object representations, which corresponds to step 1a in Goldstein's model (5). After this blurring of self-boundaries, Betty started to project her sexual and aggressive feelings on her cousin and boss, and at the same time she projected her hopelessness and suicidal ideas to the internalized representation of her brother. When the reinternalization of desperate thoughts began, Betty became acutely suicidal, which corresponds to step 3 in Goldstein's model (5).

It is debatable whether we can call Betty's intrapsychic mechanisms (described above) as projective identification proper, because there was not any actual recipient of the projection. Some authors think that projective identification presupposes interaction between projector and object (24). But others, such as Meissner, consider projective identification as totally intrapsychic process (26). This intrapsychic interpretation about projective identification permits us to consider that self-representations can be projected as well to the internal object representations as to the external objects. But regardless of these different views, we can use Goldstein's model as a illustrative heuristic model. Betty first projected her depression and suicidality to her brother's internal representation, and thereafter identified herself with this object representation.

This case example can, of course, be understood also entirely in the terms of Freud's original theory of internalization (25), without any reference to projective identification. But especially in the situations where suicidal patient and the object of imitation have been total strangers to each other, the intrapsychic interpretation of projective identification described above may be helpful. When we try to analyse, for example, a suicide epidemic among schoolchildren, it is difficult to assume that the first suicide had been a narcissistically important object to every other children in the epidemic. I find it more natural to speculate that some children with weak identity first project their best qualities to the internal representation of the first suicide and thereafter identify themselves with this representation. Empathy may act as trigger for the projection.

Death or suicide gives usually rise to the retrospective feelings of empathy in relatives and friends. Beres & Arlow (27) have written that transient identification is normally a part of the empathic process. When the only object left for identification is its internal representation in the mourning one, the feeling of oneness and blurring of self- and object-representations is at hand.

This is especially true when the borders of the self are weak beforehand, like with borderline or psychotic patients. At the same time when this blurring of self-borders occur, the mourning one may have to struggle against the conflicting emotions of guilt, hate and regret. This kind of situation may end in alternating patterns of projection and introjection between the self representation and the object representation of the deceased.

Conclusion

The internal world of a suicidal patient is usually very complicated; crowded with conflicting and rapidly changing emotions and intrapsychic mechanisms. The intrapsychic concept of projective identification may be a helpful tool in the psychotherapy of suicidal patients.

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