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Convergence and Non-Convergence: stories of elderly who have attempted suicide and the Integrated Care System in Porto Alegre/RS, Brazil

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Abstract *This article is the product of research undertaken in the city of Porto Alegre, in the Brazilian state of Rio Grande do Sul. The goal is to bring to light and discuss a little known phenomenon - attempted suicide by the elderly. Under-reporting of suicide attempts among this population makes it difficult to place this serious public health problem on the political agenda. As part of this study, we interviewed not only elderly persons who had attempted suicide, but also their family members and mental health and emergency and urgent service professionals. These interviews took place during the course of 2014. From a textual discourse analysis of the various reports, there emerged a category we will call Convergence and Non-Convergence, which deals with the relationship between the elderly population's need for care and the healthcare model in use. This study uses three short stories of individuals to question the biomedical model of serving risk situations, stressing the concept of an Expanded Clinic to provide integrated healthcare. This concept focuses on the different types of care and the uniqueness of each user, which often the biomedical model neglects. This study also highlights the need to develop a line of care for the elderly, with investments in continued education about active aging and care in times of crises, articulating a cross-sectorial network.*

Key words *Attempted suicide, Elderly, Care Network, Biomedical Model, Expanded Clinic*

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Introduction

Everything depends on how you look at it.
Rubem Alves

This article proposes to describe and analyze what the elderly find is available to them when they use the healthcare services available before and after they have attempted suicide, and the implications of the service they get on their lives. This study was taken from a national study entitled *Study of Suicide Attempts in the Elderly from the Point of View of Public Health*, coordinated by the Osvaldo Cruz Foundation - Jorge Careli Center for Studies on Violence and Health (Fiocruz/Claves), covering all five regions of the country: North, Northeast, Middle-West, Southeast and South.

In addition to statements from the elderly themselves and their family members, this study also took into account reports by healthcare workers in emergency/urgent and specialized mental health services. An analysis of the data available revealed, as the main category, how the elderly relate and interact with healthcare services. This enabled questioning the service model offered in situations of crisis or that are life-threatening. The study also addressed other possible interventions. The fieldwork was performed in the city of Porto Alegre by a team of healthcare researchers. The location was selected based on an increase in suicide attempts among its residents 60 years of age and older. According to the Rio Grande do Sul State Poison Control Center[1], which is the body responsible for registering attempted suicide attempts by poisoning, the incidence of suicide among the elderly in Porto Alegre is 15 in 100,000. This is 70% above the average rate in the state for the same population group, which over the course of the past nine years has been a steady 9 in 100,000.

Health authorities in Rio Grande do Sul are concerned about the numbers of suicide attempts, which may be even higher due to under-reporting. Between 2005 and 2013, 34,166 people attempted to kill themselves with poison. This is an average rate of 36 in 100,000. Although higher rates are found in the 15 to 19 year-old range (71/100.000), what calls attention is that among the elderly, this number has consistently gone up year by year, from 85/100.000 in 2005, to 149/100,000 in 2013.

Just as the magnitude of the problem that is the target of this study is unknown, suicide prevention is not part of the agenda of public health authorities, nor is it a demand on the part of social control. Our fieldwork revealed that many of the urgent and emergency care services do not have reporting systems in place, although they recognize the importance of mapping attempted suicide among the elderly in order to address this serious public health issue.

The population of Porto Alegre, the capital of Rio Grande do Sul, is 1,409,939, 15.04% is 60 or over. According to the 2010 Census, it has the largest elderly population of any Brazilian city, larger even than Rio de Janeiro, traditionally considered the city with the largest percent elderly population[2]. Something else that is a characteristic of Porto Alegre, is that it is ethnically heterogeneous, having welcomed immigrants from numerous parts of the world, as well as from other parts of the country and state due to urban migration. This type of mobility resulted in ample psychosocial, economic and cultural maladjustments[3].

The World Health Organization[4] considers suicide to be a highly impactful social phenomenon, the demand for which is increasing among healthcare and multi-sectorial services. Estimates suggest that for every suicide there have been 10 to 20 attempts, which by and large are handled by urgent and emergency services, which are supposed to refer the patient to specialized services. In many cases, these people have sought help from someone in the healthcare system before attempting suicide, yet this was not identified as a high-risk situation. Thus, it is important that this theme be addressed from different perspectives. In this article we do so from the point of view of the elderly patient him or herself, as well as his/her family members and healthcare professionals.

Methodology

This study started in 2013, and contact with participants happened primarily in the first half of 2014. Six elderly individuals in Porto Alegre were interviewed, as well as three healthcare professionals (two in Porto Alegre and one in Santa Cruz do Sul). The data analyzed is part of the database for the nation-wide study mentioned above. Participants were contacted through the FEPPS (State Foundation for Health Research and Production) Poison Control Center, and CEVS (Rio Grande do Sul State Health Vigilance center), as well as the urgent and emergency services in Porto Alegre. This study was approved by the Research Ethics Committee of the Porto Alegre City Department of Health.

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Locating elderly persons willing to talk about their experiences regarding attempted suicide was one of the major hurdles this study experienced. Some claimed they were in crisis and not fit to participate, others denied any suicide attempt, and still others were being treated by the healthcare system and refused to discuss the topic with anyone other than their reference care provider.

Interviews with healthcare professionals, the elderly and their family members used tools developed by the study group to be applied nation-wide. Interview scripts covered the following fields: interviewee identification, personal and socioeconomic profile, and conditions and impact of the suicide attempt. When interviewing healthcare professionals the study listened to their career path and experience serving people who had attempted suicide, and the hurdles and potential they have faced to address this phenomenon. Interviews with family members focused on interpreting the reasons why the elderly individual had attempted suicide. Telephone contact between the team and most of the participants, during which the study was introduced, became an important element for this study. It enabled answering requests for help and identifying why the elderly person contacted did not wish to participate in a study of this type.

The interviews transcribed were been submitted to textual discourse analysis[5] - methodology to analyze the content whereby a text is disassembled into units of meaning after numerous readings. The approximation relationships that can be established between the units of meaning give rise to categories, which gain consistency from theoretical contributions. Reorganizing the material in a system of categories enables a "renewed understanding of the whole"[5] that cannot have been foreseen ahead of time. In this particular case, the analysis process articulated elements of group health, psychoanalysis and psychiatry. The effort to produce and explain meanings to value the perspective of the research participants was part of the analysis cycle.

Convergence and Non-Convergence

In this paper, we highlight one of the emerging trends in the analysis, which is the relationship between an elderly person at risk and the healthcare services available, which here we are calling "convergence and non-convergence." We will describe three short stories to illustrate this.

First Story

Ms. L, a 66 year old woman had lived a productive and financially organized life as a nursing technician. She started to show signs of depression when her marriage broke up and her children left home. She sought help at the Affective Disorders clinic of a general hospital, and remained linked to this service for six years as a member of a therapy group. At some point, she became uncomfortable with the increasingly large number of people in the group. *At first it was good, but then a lot of people joined, each one bringing a slew of problems. Sometimes I would be doing well when I arrived, and felt worse when I left.* Not only that, the reference professional changed frequently and the Ms. L decided to abandon treatment. *I left with no medication... The doctor told me that* [...] *if I wasn't feeling well, I was not to take anything. So I didn't, I had nothing and ended up hospitalized. I was hospitalized for more than six months, going from one place to the other.* After a period of disorganization, the patient presented a clinical situation of depression, loss of appetite and rapid weight loss. *I couldn't taste anything*. That's when she made her first attempt at suicide, ingesting an overdose of medication. Her sister had her committed to a psychiatric hospital.

The patient's history includes other hospitalizations for clinical reasons. For a while, the absence of any desire to live during successive hospitalizations was treated as a neurochemical disorder only, and no other form of therapeutic (psychosocial) intervention was offered. With no family support, this woman tried to find what was available in the community, and joined a neighborhood association that sponsored leisure activities such as barbecues, dances and games. This effort at self-care to overcome the situation allowed her to build new socio-affective bonds that restored her pleasure at being alive. At the time of the interview, she was well, with no suicidal ideation.

Second Story

Mr. A, an 82-year-old man, had focused on his family (children and spouse) for his entire life. He and his spouse had lived together for over 50 years. In his old age, he had to face the deteriorating health of his wife, who suffered from neurological problems - possibly Alzheimer's Disease. With no help from his children, he became his wife's sole caregiver. *He was tired of fighting with her. "I took care of her day and night.*

[...] *I had to take care of her medicine. I had to do it all alone. I had to take care of her food* (sic)".

Emotional exhaustion, compounded by the recent discovery of a prostate tumor, led him to attempt suicide. *I was exhausted. It was raining. I took a whole lot of medicine. I felt alone and afraid*. He ended up in the ER and his stomach was pumped out. However, the burden of having to take care of his wife, the absence of any family support and limited financial resources led to a second attempt: *I bought some rope. Because I was poor and had no help*. This time around, his son arrived in time to lift him to avoid actual hanging. Mr. A adds that had he used a gun he would have succeeded in killing himself.

The difficulties this elderly gentleman faced seem to have worsened after he had to sell his home, which he had bought with a lot of effort, having held down more than one job for most of his life in order to provide for his family. With the loss of his home and with his wife placed in a geriatric care facility against his wishes, he found himself living precariously in borrowed rooms at the back of one of his children's homes. Furthermore, a diagnosis of personality disorder[6] while hospitalized in a psychiatric ward, after his second suicide attempt, had an iatrogenic effect on his relationship with his family. His children started to see him as an *ill-intentioned manipulator*. They interpreted his suicide attempts as an act of cowardice designed to make the family feel guilty, and became hostile to their father, and were unable to understand what he was going through, passing moral judgment.

When conveying his story, Mr. A said he visited his wife in the geriatric clinic every day: *My reason for living the rest of my life is to see her*. Despite this motivation, the risk of suicide remains, as he continues to feel worthless: *I am becoming a leftover, a piece of trash*. He mentioned feeling lonely and suffering with the estrangement of his children: *My days are very sad. I see them* [daughter-in-law, grandchildren and children], *but I don't talk to anyone*.

During the interview, we realized that Mr. A's only relationship with the healthcare services was to get his prescription renewed. Despite family conflicts, Mr. A demonstrated a desire for change, and made intense use of the moments he shared with the researchers. In order to offer him integrated services, we contacted social and health services to help strengthen his family bonds and monitor his basic needs. He was also instructed on how to get special medication free of charge through the Rio Grande do Sul State Department of Health.

Third Story

Mr. C is a 64-year-old male with a history of successive bad luck with his jobs, leading him to resort to family members for financial help. He has always demonstrated dependent behavior in terms of his family, alcohol, tobacco and gambling. As a result, in the discourse of his wife and daughter, he comes across as a failure.

Despite numerous attempts at treatment, he was always discharged, as he was unwilling to give up alcohol: *If I have to stop drinking I just won't get treatment. Antidepressants and alcohol don't go together*. On the day before he attempted suicide by hanging, he had gone to a healthcare center for a visit with a clinician, where it appears the local team did not realize he was in a crisis situation, as the family receive no instructions on how to protect him.

On another occasion, there was a possibility that Mr. C might be able to join a CAPS (Alcohol and Drug Psychosocial Attention Center) for treatment for alcohol abuse. His daughter had begged him to go. However, once again he refused to stop drinking, which made adherence to treatment impossible. He was discharged from the program as he did not meet the criteria, specifically abstinence from alcohol.

Mr. C reported having had more than one mystical experience: *The Sacred Heart of Jesus and Mary appeared before me and told me I would suffer a lot before dying, that I would end up under the bridge. I don't even like to think about it*. His daughter explained that he fully believed this tragic destiny would happen. His emotional instability also manifest as intense irritation, which resulted in his being aggressive towards his wife and daughter, and the healthcare team. *He attached the psychiatrist, I was there, my mother and I, and he just attacked the guy. He did not respect the doctors who were trying to treat him*.

His mystical visions, forecasting a somber end, and his failure in the family discourse seem to have left him no option other than to attempt suicide, although he was unable to explain why he had done this. As far as the instructions received from the healthcare services go, the family "understood" that there was nothing to be done and they should just abandon him. According to his daughter: *They said he was a selfish person and impossible to live with, and that my mother and I should either leave or put him out of the house.*

After the interview, we learned his family had put him in a home. Before this, a visit to the psychology service at the Basic Healthcare Unit

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(UBS) to which he belonged was arranged by the researchers, who explained the complexity of the case and demanded that they see Mr. C.

Linking the three stories

These stories show that interaction with the healthcare services resulted in very different outcomes. Clearly all of the elderly had sought help for their suffering and abandonment, mobilizing family members and healthcare services before attempting suicide. However, and especially in a crisis situation, the attention sought was not sufficiently welcoming or resolutive. Despite their differences, we found some commonalities these three cases share: they had healthcare services as a reference, even though the service did not respond to all their demands; they were aware of the health resources available and, in some cases, they also attempted to defend their lives, within their range of possibilities[7].

Regarding difficulties or limitations, the stories of these elderly people show us that the services they reached out to had their own characteristics and a model of service known as biomedical, which focuses on "medicalization". "The term "medicalization" was coined by Illich to describe the fact that medicine and its technological apparatus are increasingly invading our individual lives or steps in our lives [...], now submitted to interventional care and strategy, regardless of whether or not there are objective symptoms of morbidity or pathology (one should remember other conditions that have been "medicalized" and become the focus of medical attention, such as depression, alcoholism, drug addition, sterility, homosexuality and other not socially acceptable behaviors [...]"[8]. Here, drugs are used for "purposes beyond the essential function for which they were discovered or created [...]. Business interests encourage people to believe in a "magic pill", something that would cure all evils"[8]. In the three stories above, an approach prioritizing medication was not enough to avoid suicide attempts, as by reducing the health-disease process to its biological dimensions it ignored a "far wider range of psychological and economic-social variables"[8]. The human afflictions of these patients were often naturalized and reorganized into disease, for which the ingestion of psychopharmaceutical drugs should have worked[9]. In this model, the nosographic diagnostic is more important, as it will be used for drug prescription and for defining how the patient will be handled by family members and [healthcare teams]. By including only the disease in patient history, as happened with Mr. A and Mr. C, elements of their history that might serve as life anchors are not enabled.

In both cases, the emphasis was on diagnosing a disease, and the instructions given family members as a result of this diagnosis had iatrogenic effects, encouraging moral judgment. The symptoms presented by these elderly persons were considered a "way of calling attention" to obtain secondary benefits, thus banalizing the plea for help contained in these desperate acts. In the case of Mr. C these measures encouraged abandonment and rejection, resulting in antagonistic family relationships. In the case of Mr. A, instructions received from the healthcare system led the family to view him as "manipulative and ill-intentioned". Whenever the psychopathological diagnostic sticks to a standard that is the same for all patients, rather than the unique expression of disease progression[10], the specificities and complexity inherent to individual stories and life contexts are ignored, both in terms of guidelines given to the patient regarding risk, as well as the support instructions given to the families. As far as we can tell, existential issues, a core element when designing a Unique Therapeutic Plan, were ignored. Such a plan requires understanding the situation from the view of the elderly patient him or herself, the family and social network, and incorporating the viewpoint of the professionals in the different parts of the multi-sector network to create and discuss proposals, so that one service may serve as backup for another. We point out that one cannot change FOR someone, but WITH that person, bearing in mind the individual's potential, needs and desires, as well as past care strategies. This constitutes a unique body of knowledge on the individual, about what worked and what did not work, in how the elderly patient led his or her life.

While these studies clearly show the use of a wide array of drugs, we found scant investment in the relationship plane (ties), in listening to what these elderly patients had to say and offering them alternative healthcare strategies. This insight was confirmed by the healthcare professionals we interviewed. They believe the shortage or lack of other therapeutic approaches is due to a shortage of human resources, among other reasons. In some services for instance, there is a waiting line for psychotherapy. The professionals involved try to overcome these problems to the extent they can, especially in cases of attempted

suicide: *Normally we will call a colleague, explain the situation and try to get them to understand, but what we hear back is: I'm sorry, it's just that there is only one of me and already I have a huge waiting list. One therapist is on vacation, and the other on maternity leave.*

The absence of a line of care that includes criteria to classify risk, around which all of the different services are aligned, makes professionals feel impotent and miserable because they are simply unable to meet the demand for their services. *Can you imagine how a lone psychologist must feel, working at a clinic with a huge list of potential patients, knowing this list includes people with terrible stories and an urgent need for treatment*? (healthcare professional in Porto Alegre).

Whether it is a shortage of professionals or the biomedical model, the fact is that none of these elderly patients were sent to integrated healthcare care services. Ms. L who joined a community association that welcomed her and gave her the support she needed to overcome a feeling of loneliness, did this on her own initiative, perhaps driven by memories of how good she felt when she was part of a mental health group years before. Mr. A was only referred to the group that strengthens family ties, provided by CREAS (Special Social Services Center of Reference), because the researchers intervened. The same can be said of Mr. C, who was referred to the mental health team again by the researchers. Based on these scenarios, it is clear that the multi-sector network (social and healthcare services, neighborhood and housing associations, workshops, income generation, community centers, crafts, art, music, dance, drama, sports, leisure and culture, among others) is still very fragile.

It is worth pointing out, however, that there is a new model being designed, which is different from the biomedical model that still prevails. This is the model of expanded clinics, where listening to what patients have to say is an important element, as it enables people to resignify their story and build a place where they can live. Within this model, the so-called "witness clinics"[11], designed to help users bear their pain rather than abandon them, and especially to give them a place to be heard and where they can share their stories with others, are gaining importance.

To consolidate this rationale of patient service, another promising policy is what is known as "Damage Control", which recognizes each user as a unique individual, designing strategies that focus not only on abstinence as the only goal to be achieved, but the very defense of his or her life"[12]. This guideline bets on increasing degrees of freedom and co-responsibility of the players involved. Under this guideline, there are many, sometimes opposing treatment outlooks. In the case of Mr. C, damage control might have opened up possibilities in his life that that might not have required him stop drinking to receive treatment from the mental health services. We know that oftentimes alcoholism is comorbid with depression or melancholy[13], which must be treated for an effective therapeutic approach. Thus, demanding abstinence in order to maintain treatment may worsen the patient's health and increase the risk that he or she may make an attempt on his/her life.

We see professionals who still work with abstinence as the core element of treatment. This makes it difficult to use Damage Control as a guideline, which would enable developing protective strategies that would reduce the user's subjective and social risks. In the case of Mr. C, that fact that he remained untreated and continued to use a psychoactive substance increased the likelihood of attempted suicide, which is 60 to 120 times more prevalent among alcoholics than in the population at large[14].

The absence of a service that will listen to the elderly and a reference professional to whom they can go with questions may make them more vulnerable to the risk of suicide. Had any healthcare professional contacted Ms. L, or paid her a home visit when she stopped coming into the service, she might not have abandoned treatment and remained without her medication and the benefit of group therapy. We can assume that the bonds between group members were also fragile, as none of them made any attempt to get her to remain or come back. In the case of Mr. A, a reference professional could have taken care of the necessary referrals, articulating backup services and facilitating access to medication through SUS.

The professionals interviewed confirmed what emerged from the stories of the elderly, describing the problems they faced getting service in crisis situations. Many are afraid to ask users about suicide plans or suicide ideations, lest they be held responsible for the life of the elderly without any system backup, as service flows have yet to be implemented, even in emergency services. This means that each professional must take initiative to create a network.

Professionals also claim that some of the drugs they require is not available in SUS, making it hard for this population to access the medication they need. The elderly we interviewed paid for their own psychotropic medication, believing

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that those provided by the state are difficult to get, the absence of information and the complexity of the processes involved. Family members mentioned how hard it is to find specialized help for the elderly, and the fact that they do not know who to turn to. Another element that demonstrates the fragility of the network is that social services is more likely to address situations where violence has been committed against the elderly, and seems unprepared to handle attempted suicide. This gives rise to a complication, as lack of understanding on the part of healthcare professionals leads to a distorted vision of the reality regarding suicide attempts, and may result in an a critical association with senility, attempts to call attention and being in an altered state of consciousness. In actual fact, they are unprepared for qualified listening and for addressing elderly patients in the context of what they are suffering or experiencing, and the social and family context in which they live.

Every NODE in the network is important.

Final Considerations

Although Porto Alegre has a high incidence of suicide and attempted suicide by the elderly[15], this is not a well-known phenomenon due to under-reporting. Hence the importance of studies on the theme, which in addition to making the problem more visible, might also foster the development of an "Elderly Line of Care", which would be a major advance for the capital of the state of Rio Grande do Sul. In this study, an analysis of the data enabled problematizing the biomedical model in different situations where suicide was a risk, launching the challenge of designing a different model of care. An Expanded Clinic, by combining other welcoming and listening strategies, could help avoid suicide attempts, but is not yet consolidated practice in how services are organized and the working processes.

One should point out that in their reports, the elderly explained that they had not found any place they could tell their story, where they would make sense to those who listened, resulting in the possibility of care and connection. The data analyzed revealed that the elderly are often judged as incapable or problematic due to losses that are typical of their age group, and lose their place and the respect they built up over a lifetime, precisely when they have the most need for recognition from their family and society in general. According to Gutfreid[16,] narrative is one of the best ways to leave a legacy and be born subjectively. It transforms gaps into good and well-told stories, even if not everything can be said. Convergence happens when what is being heard provokes feelings among those telling the story, and those listening to it.

Integrated care must include approaches that respond to the degrees of dependence presented by the elderly, with the necessary backup of a team of professionals. This requires developing a network of cross-sectorial care. A "Unique Therapeutic Plan", designed with the patient and the different network references, should be the guiding thread for such a process. What characterizes this type of Clinic is expanded healthcare equipment and repertoires, including the already known damage control strategies, creating spaces within and outside these services where the elderly can talk about themselves (conversation groups, forums, healthcare conferences and other similar structures). An investment must be made in shared responsibility between users, family members, professionals and the community in general. This perspective favors creating a suicide-prevention line of care[17].

To overcome the remaining limitations one must also invest in continued health education, bearing in mind the elderly in situations that involve suicidal behavior (suicide ideation, plans attempts and suicide itself), in diversified campaigns and reorganization of cross-sectorial working processes and flows, with the involvement of society.

A "Line of Care for the Elderly" from the perspective of public health would include a set of measures running from skilled approaches for crisis situations and post-crises follow-up, overcoming the situation and quality of life. This strategy often requires observation, intervention and social actions in the environment that originally led the elderly to desire to kill him or herself. It also requires integrated healthcare, considering that suicide attempts are often associated with physical and mental disease, the loss of independence and socioeconomic problems.

To finalize, we would reiterate that the areas in which one can intervene in this reality show new models that favor and foster active aging, with measures that depend on the government, but that also involve numerous instances and social players, such as rights councils and associations, in formulating an integrated, multi-sectorial policy for the elderly. One must always remember that the elderly must be part of any measure taken on his or her behalf, not only to make sure care is

adequate, but because the individual has desires, feelings and purposes, and is thus a subject in the processes of overcoming issues and family, community and social involvement.

Collaborations

M Conte, CW Cruz, CG da Silva, NRM de Castilhos and ADR Nicolella participated equally in all steps of drafting this article.

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