Counselling Psychology Quarterly, 2002,
Vol. 15, No. 1, pp. 1–22

BrunnerRoutledge Taylor & Francis healthsciences

COUNSELLING IN ACTION

Self-confrontation interview with suicide attempters

LADISLAV VALACH[1,2], KONRAD MICHEL[1], PASCAL DEY[1,3] & RICHARD A. YOUNG[4]

[1] *Psychiatric Out-patient Clinic, University Hospital, Berne, Switzerland;* [2]*Rehabilitation Centre, Medical Clinic, Buerger Hospital, Solothurn, Switzerland;* [3]*Institute of Psychology, University of Berne, Switzerland;* [4]*Dept. of Counselling Psychology, University of British Columbia, Canada*

ABSTRACT *Psychiatric and psychological assessment after parasuicide is characterized by a number of difficulties. The interview is a strategically complex task for the patients trying to accommodate the wishes of the psychiatrist/psychologist and their own goals. The psychiatrist/psychologist on the other hand needs to gain information about the event and the patient's mental state, has to assess the risk of further suicidal behaviour, and has to motivate the patient for treatment. In our experience a routine video prompted recall or self-confrontation interview, can be a helpful means of talking with the patient about his or her feelings and cognitions during the interview. Furthermore, it allows clarification of the processes leading to parasuicide. The procedure of administering a self confrontation interview is described, the theoretical background for interpreting the results is outlined and some examples of patient interviews are presented. It is demonstrated that this method allows access to additional information on the patients' thinking and emotions during the interview and that it also provides more details of the suicidal process.*

Introduction

An interview is the core procedure and technique in disciplines and professions in which interpersonal contact is an important source, a means but also a target of the professional work. Clinical interviews include a number of features that the interviewer has to consider. A clinical professional has not only to gain information but also to secure the patient's cooperation for further treatment. Interviewing in a psychiatric institution requires special skills as patients are not only in physical distress but also mentally under strain. Finally, an interview with patients after a suicide attempt poses further

Correspondence to: Dr L. Valach, Rehabilitation Centre, Medical Clinic, Buerger, Hospital Solothrun, 4500 Solothurn, Switzerland; e-mail: lvalach_so@spital.ktso.ch. As of 1 November 2001 Dr L. Valach is also affiliated to: Division of Psychopathology, Faculty of Philosophy, University of Zurich, Psychiatric University Hospital, Lenggstr. 31, 8029 Zürich, Switzerland.

Counselling Psychology Quarterly ISSN 0951–5070 print/ISSN 1469–3674 online
http://www.tandf.co.uk/journals
DOI: 10.1080/09515070110101487

difficulties as the patients had not only faced a decision about life and death but had opted to harm themselves. In this situation the patient is far from being a bystander of the physician's fight with the causes of illness and of death but an active agent who can take crucial decisions. An interviewer in this situation should allow the patients to express their motives and the relevant life-career aspects. Obviously, the view that the patients themselves are the agents in the healing processes is widely used in psycho-social medicine but seldom in a life-threatening situation.

It is the purpose of this article to point out some of these specific issues in the therapeutic interviews with suicide attempters and to describe some methods of counter-balancing the problems the psychiatrist or psychologist encounters.

Assessing the suicide attempter

The situation of the patient

He has, maybe sometimes only a couple of hours or days ago, tried to escape from an intolerable situation by harming himself. He has received treatment for the consequences of parasuicide by overdosing, cutting, jumping, etc. Recovered, and maybe still drowsy, he has to face a psychiatrist/psychologist unknown to him and he is expected to talk about what made him do the act of deliberate self-harm. Most probably he feels ashamed. Most probably he is afraid of not being understood. Maybe he finds that the reasons may sound too trivial to talk about, maybe he is afraid the psychiatrist/psychologist will consider him mentally ill and send him to the psychiatric hospital against his will. In short: he finds himself in the role of the patient, where the power of decision is taken out of his hands as soon as he engages in the interview.

The situation of the psychiatrist/psychologist

She is called to a general hospital ward to attend a suicide attempter. She should find out what happened, what the psychological situation of the patient was, what the situation is at present and how severe the suicide risk is. She has to choose a form of management, and she has to find out if the patient will comply with her decisions. In most cases the psychiatrist/psychologist will try to gain the motivation of the patient for psychiatric/psychotherapy treatment focusing on the problems which made the patient harm himself.

Obviously, the goals, the attitudes and the motivation of these interview partners are very diverse. The patient may try to play down the importance of the event and the psychiatrist/psychologist may feel that the patient does not tell her the truth.

Considering the key differences in the interview with a suicide attempter in comparison to other interviews, and the differences in the situation in which the two interview parties find themselves, a new approach to the interview process is proposed. It will not primarily be seen as an exchange between two participants but as a systemically organized joint action. The main features of such a joint action are: (1) the requirement of a joint goal directing the joint performance of the interview; and (2) the dual structure of the interview process, i.e. the joint action and the individual action (Valach *et al.*, in press; von Cranach *et al.*, 1986; Young, Paseluikho *et al.*, 1997; Young *et al.*,

1997). This means that the actions of the professional and patient are directed by a joint goal however different the contents of the individual goals are. If the individual goals cannot be adjusted to provide an agreeable content for a joint goal, the performed action will lead towards neither goal of each of the two parties. The dual nature of such a system of joint action requires that the action of the professional-patient dyad and the actions of the participating individuals have to be distinguished. The processing of cognitions and emotions in both parties is also organized in an individual and in a joint way. The communication provides the knowledge processing at the joint level of this system and the thinking and feeling of the individual provide the individual processing. Steering and control is achieved by communication. Self-regulation of a joint action is often achieved without overt communication as automatic self regulation in individuals often proceeds through subconscious processes. Consequently, there are two levels of processing to monitor: the level of individual action and the level of joint action (von Cranach *et al.*, 1986).

In an interview with a patient after a suicide attempt the task for the interviewer is a complex one. Several studies have made it clear that there is a serious communication problem between the suicidal patient and the professional helper. Most people who commit or attempt suicide are under the care of a GP or a medical specialist to whom they could turn when in a suicidal crisis, yet even when patients see their doctors shortly before a suicidal act, only a few of them openly mention their suicidal thoughts (Isometsä *et al.*, 1995; Michel *et al.*, 1997; Öjehagen *et al.*, 1991). In his classical paper, Murphy (1975) pointed out that 91% of those who died by suicide had been under the recent care of a physician, and over half of those who died of an overdose had received the prescription within a week or less before dying. In an inquiry, 48% of GPs were surprised that their patients had committed suicide (Michel, 1986). Suicidal patients often do not consider contacting a GP or psychiatrist because they perceive them as unhelpful (Hawton and Blackstock, 1976; Wolk-Wasserman, 1987). Following a suicide attempt many individuals say they felt ignored by health professionals (McGaughey *et al.*, 1995), or they say that nurses and social workers were much more helpful than doctors (Treolar and Pinfold, 1993). And when patients are not sure that they will be understood and accepted, they are likely to keep suicidal thoughts to themselves (Michel *et al.*, 1994). Suicidal adolescents in particular are reluctant to seek help (Choquet and Menke, 1989). Culp *et al.* (1995) analysing data of 220 students of whom more than half had symptoms of depressed mood and a third had thought of suicide, reported that half of the students with symptoms of depressed mood did not ask for help. Of those, two-thirds believed they had to take care of their problems themselves. There are some research reports indicating that patients tend to hesitate to disclose suicide attempt related information as well as suicide ideation. Kaplan *et al.* (1994) report that questions concerning recent suicidal ideation, were disclosed more readily on the self-report than in an interview. Petrie and Abell (1994) even suggested that computerized assessment may help as it was preferred in their study by a majority of suicide attempters in comparison to a traditional doctor–patient interview. The acceptance of the computerized assessment was greater in suicide attempters with higher levels of suicidal ideation and hopelessness and lower levels of self-esteem. The authors maintained that this is because people avoid to address potentially sensitive or embarrassing issues.

A further indication of a communication problem between patient and health professional is the fact that compliance for psychiatric/psychotherapic aftercare is notoriously poor and that the results of psychiatric treatment evaluations in terms of repeated suicidal acts have so far been disappointing (Hawton *et al.*, 1999; Möller, 1990). Because of the lack of co-operation of the patient after a suicide attempt complicated and expensive measures would have to be taken in order to stay in touch with the patients and decrease the chance for a consecutive suicide attempt (Van Heeringen *et al.*, 1995). There is a clear need for more effective treatment models. It has to be considered that thinking and talking about the time before the suicide attempt and the suicide act itself is very painful for many patients—the most frequently mentioned reason for attempting suicide is an unbearable situation or unbearable thoughts (Kienhorst *et al.*, 1995; Michel *et al.*, 1994).

It is therefore necessary to closely study the interviewing process and interaction between the suicidal patient and the health professional. Feelings and thoughts related to monitoring and steering during the interview are not normally the subject of the interview. However, this information is often crucial and can lead to understanding of the subtleties of the interviewing process and to establishing a therapeutic relationship. For instance, an interview situation of conflicting goals will lead the patient to closely monitoring what to reveal and what not. Also, patients want to deliver their story as they want to interpret what happened and how they want to be seen by the psychotherapist. Any interruptions or a question which does not promote this particular story is seen as an uncooperative gesture in the task of developing a story the patient would approve of and may inhibit the motivation of the patients to adhere to the suggestion of the psychotherapist.

It must be assumed that suicide attempters come to the interview with their own goals in mind. However, these goals are not just personal strivings but they are strongly related to their situation. Patients may feel insecure and ashamed of what they did. At the same time many of them will have a strong urge to provide their narratives of the actions. The special meaning of being able to produce a 'good' narrative of the suicide career, project and action lies in the association of the narrative production with the incomplete memory of the traumatizing event. It has been suggested in the research literature dealing with PTSD particularly in victims of extreme violence and abuse that the memory of the people regarding the events (as part of the project or the actual action) is somehow distorted (Herman, 1993). It is the goal of a therapy of traumatized people to recover their ability to provide narratives of the traumatizing events they have not forgotten but which they present as a set of images and isolated events. Narratives are an important backbone of the communication of events to the other people who did not witness the traumatizing events, in our case the suicide episode. The people who are not able to provide such a narrative put themselves under pressure in order to construct adequate narratives. If inhibited by circumstances or by their interaction partner, in our case the interviewer, their satisfaction with the encounter is much lower than would be the case under other circumstances. To understand this more clearly, in interrupting a suicide narrative the patients are being hindered in their attempt to heal themselves. This is not just the issue of interrupting certain functions but it referrs to the issue already addressed by Zeigarnik (1927). In another understanding it can be seen under the main assumptions of the

frustration-aggression hypothesis (Dollard *et al.*, 1939). Suicidal patients will usually not show frustration or anger, but they will withdraw from the interview. Additionally, in disturbing the active attempts of the patients to strive for a good narrative they are being hindered in their active coping which has been found so often to be beneficial in problems, life events and illnesses. There are some other patients who would rather not talk about their suicide at all. For these patients being asked questions and answering them very briefly may be the preferable way of conducting the interview. However, it is known from domestic violence that violent actions of a spouse proceed in a certain order and that the post attack phase is characterized by certain behaviours and attitudes not dissimilar to the post suicide attempt patients. The abuser or the suicide attempter feels temporarily in control of self, feels shame and guilt, is afraid of their own behaviour, minimizes the abuse/the suicide, promises never to do it again, is afraid that others and institutions may get involved. Consequently, if the questions get too detailed and the interviewer is insisting on explicit information the interviewee will be dissatisfied in the same way as the suicide attempter who wants to deliver his or her own narrative.

In our experience a video self-confrontation interview directly following a conventional interview is a helpful means to solve the complex task of interviewing a suicide attempter. Here the method of the self-confrontation interview (sometimes also called a video prompted recall) is described. Not only as a means to collect data on internal processes (cognitions and emotions) related to the interview, but also as a means to clarify the reasons and causes of the suicide attempt.

The video self-confrontation interview

The video self-confrontation interview as described here basically consists of a video playback procedure. It requires video recording of the patient-psychiatrist/psychologist interview and playing this recording back immediately after this interview to the patients and stopping after certain meaningful episodes (between 1 and 2 minutes). The suicide attempters are then asked to report on thoughts, emotions, feelings and sensations they had at the time of the interview. This session is again recorded for purposes of transcription and analysis (see also Kalbermatten and Valach, 1985; von Cranach *et al.*, 1982; Young *et al.*, 1994).

The method itself in its individual features is not unknown in psychology and in psychotherapy research and practice. The term self-confrontation is used in various contexts. Self-confrontation is a term used by Hermans and colleagues in their work in which they monitored personal meaning and value system (Hermans, 1992; Hermans and Hermans-Jansen, 1995; Hermans and Oles, 1994; Hermans and Oles, 1996; Hermans *et al.*, 1990). They developed the method of self-confrontation in order to contribute to the construction and reconstruction of the self as an organized process of valuation. They invite subjects to give their own view on their past, present and future world in their own terms. Although the procedure involves an interaction of the client with the information from the first investigation it is not a video self-confrontation focusing on actions. The primary interest of this procedure lies in the changes of the client. Many other authors were also mainly interested in changes induced by the self-confrontation in psychotherapy (Daitzman, 1977; Grube *et al.*, 1994; Ronge and

Kuegelgen, 1993; Sanborn *et al.*, 1975; Schwartz and Inbar-Saban, 1988; Vandereycken *et al.*, 1992). They shared this orientation with many others using video playback for similar purposes (Andrew, 1993; Dowrick, 1991; Fuller and Manning, 1973).

Gibbons *et al.* (1985) described how self-awareness increased the accuracy with which patients (male alcoholics and psychiatric patients) reported on their history of hospitalization. Additional analyses indicated that although subjects generally felt worse when self-aware, they were also more accurate in their self-reports, including descriptions of their problems. Effects of self-confrontation via videotape playback on self-image and self-other discrimination were assessed by Doerr and Carr (1982). They reported that a group undertaking self-confrontation showed significant differences between pre- and post videotape playback scores indicating greater congruency between self-as-seen-by-self and self-as-seen-by-others. An early review of the reported positive and negative effects of the use of 13 specific audio-visual self-confrontation methods can be found in Daitzman (1977).

Dowrick (1991) underlined the necessity to distinguish between the self-correction and the motivating effect of video self-confrontation. It was automatically assumed in many cases of applying video self-confrontation that feedback processes as self correctional connection of output to input are at work but this can be disputed as positive feedback can also occur (Valach and Kalbermatten, 1986; Dowrick, 1991). Consequently, it has been concluded that video confrontation or feedback is not necessarily therapeutic or educational in and by itself (Dowrick, 1991).

Kagan who has been using video self-confrontation as 'interpersonal process recall' for over 30 years defines the purpose of this procedure as an opportunity to re-examine past events and in this way promote self-analysis and motivation (Kagan *et al.*, 1963; Kagan, 1978). Kagan devised a whole programme for research, training and theory building. According to a survey (Kahn *et al.*, 1979) 27% of all medical training programmes in the US reported they were using interpersonal process recall in their training.

Although the video self-confrontation interview was also used as a research tool such reports are much more rare. Recently, the video self-confrontation interview was described as a part of qualitative methodology and theory oriented research (Breuer, 1995; Kalbermatten and Valach, 1985; Valach, in press; von Cranach *et al.*, 1982; Young *et al.*, 1994). For the same reason it is known whether people regulate their weight after self-confrontation but it is not known which affective and cognitive processes are operational in a video self-confrontation interview. However, it is known that the video support improves recall of cognitions and emotions although this effect is only of short duration. The induced state of self-awareness helps in recall of emotions as well.

Theoretical assumptions

Working with a video prompting led to a certain disenchantment as the effects were not always predictable. With some exceptions most of the users of this method were not relying in their work on a comprehensive conceptualization and theory of human individual and joint behaviour or action. Consequently, some specific and limited concepts were used such as feedback, enhanced memory by video prompted recall,

taking the perspective of others, etc. Our use of video self-confrontation interview is motivated by an action theoretical conceptualization of human behaviour. The theory of goal directed action (von Cranach and Valach, 1986; von Cranach *et al.*, 1982) provides a basis for a conceptualization of joint or group action (von Cranach *et al.*, 1986) joint projects (Valach *et al.*, 1996) and career (Valach, 1990; Young *et al.*, 1996).

It is assumed that goal directed action is an important form of organization of human behaviour. A goal directed action implies a systemic order of hierarchy and sequence of multiple and parallel processing. Steering, controlling and regulation are processes in a system of super ordination and subordination in action. Goals as the top steering level of action organization are superordinated to action strategies and plans and these are superordinated to body movements. Action enfolding provides a sequential order of consecutive subgoals, action steps and elements of action. Conscious goal-setting and steering and subconscious self-regulation are as much a part of this system as attention processes and self-monitoring. It is important to underline that action comprises of manifest behaviour, subjective processing and social meaning as attributed by others. Consequently, working with an action theoretical perspective, the researcher as well as the practitioner will require several perspectives in order to organize the target behaviour into a comprehensive and systematic understanding. The manifest behaviour can be monitored by systematic observation, social meaning is best gained in observation and attribution by lay people and others and the subjective reports on ongoing internal processes are achieved by the method of video self-confrontation interview.

Additionally, in a certain analogy to the theory of goal directed action the theory of group or joint action was developed (von Cranach *et al.*, 1986). This theory allows us to see an interview not just as an exchange of utterances and interchange between two actors but as a joint enterprise, a joint action of the two participants. An advantage of this conceptualization for dealing with suicide attempters is that comparable models can be used for an understanding of the patient–professional encounter as well as for an understanding of the self harming act which is a topic of the interview.

Finally, as the human life is not a chain of arbitrary actions a conceptualization of joint projects and career was also attempted (Valach, 1990; Valach *et al.*, 1996). The action theoretical stance in developing these theories provides an additional means of understanding the role of the interview in the patients' career as well as of the suicide act in a suicide career (Michel and Valach, 1997).

This brief reference to the conceptual systems relied on while working with the suicide attempters indicates the role played by video self-confrontation interview. It contributes to each individual system reference. It provides additional information on the self harming action, it helps in integrating this action into a suicide project or career, it helps in monitoring the interview action, it helps in monitoring the individual action within the interview action and, finally, it facilitates the understanding of the patients and hopefully their motivation to participate in further treatment if required.

Video self-confrontation interview with suicide attempters

In our project (Michel and Valach, 1996) the video self-confrontation interviews with suicide attempters were integrated into consiliary services provided by the out-patients

clinic in the University Hospital. A few days after the patients were referred to the hospital they were approached by the psychiatrist (mostly KM) and were asked for an interview recording session. However, this recording often is conducted several days later due to organizational reasons such as the availability of the patient, the psychiatrist/psychologist and the researchers. This interview is performed in a room equipped with two video cameras, two monitors and video recorders. The interviews last around 30 minutes and subsequently the video self-confrontation interview is conducted with the patient (mostly LV or PD). The patients are asked to report any thoughts, feelings and sensations they may have during the interview as well as any other comments they may have. After showing them a sequence of 1–2 minutes duration, the video is paused and the patients are asked to report. The video is stopped in such a way that meaningful units are provided. This session is also video-recorded. After the video session a short debriefing is performed to ensure patients' emotional well-being.

An example

The following example is a part of the interview and the video self-confrontation interview which was conducted with a young female after a suicide attempt in which she cut her wrists. Each transcribed interview segment is followed by the information provided in the self-confrontation interview. The statements are identified as relating to certain cognitions or emotions which the patient had experienced during the interview. Additionally, based on the text of the self-confrontation interview and the initial interview the information is identified which was not offered in the interview but was disclosed in the self-confrontation interview only. Finally, a summarizing comment follows which addresses the presented information.

Interview, segment (1) A: Psychiatrist (interviewer); P: Patient

A. Well, perhaps it would be best to start with your describing briefly what happened or how it came about that you cut your wrist.

P. It happened as my mother dropped in. It was a Sunday and I had been sad about a relationship for several months. She appeared unannounced which felt like being supervised. As if she provided a 24 hour care of her daughter. And she told me that it was a heavy burden for her. I knew that. There was a big argument between my mother and myself which was not primarily about my grief but about me feeling supervised. And I told her many things I thought one should not say but it just came out.

A. Did you have a real argument in which your mother was also returning your attacks?

P. No, she was primarily stunned that I had such thoughts at all and that I saw it in such a negative way.

A. Was it very unusual to attack her in such a way?

P. Very unusual.

A. You don't usually approach her in such a confrontative way?

P. No. Normally, I know how to put forward my criticism of my mother. My mother is a person who does not accept criticism easily but if you wrap it nicely you could put it forward now and again.

Video self-confrontation interview with the patient, segment (1)

The full text of the self-confrontation interview is always more extensive than the subsequent listing of cognitive processes related to the interview action presented further below. The full text of this segment (segment 1) reads as follow (*A*: Psychologist; *P*: Patient):

A. It is relatively a long time ago since you were saying this [the responses in the videotaped interview which started about 40 minutes ago]. Do you remember what you said?
P. Yes. I simply tried to briefly describe what the situation was like before it happened.
A. And specifically, as you made the first comment there where *A* mentioned something, did anything else occurr to you which you did not say previously?
P. Actually not.
A. And how did you feel at that moment in the 2 minutes [of the interview segment]?
P. Actually, quite well. I was actually expecting this question. It was not surprising. I was thinking whether I should mention the argument with my mother . . . it is simply a bit difficult to explain, the thing about criticizing and so on. I don't want to blame my mother. She really tried her best.
A. And you were thinking in that moment that it is difficult to address this issue?
P. It was necessary, but as I said . . . the situation was simply such that I was arguing with my mother which I usually don't do. It was not in the usual tone of voice.
A. And you felt there like 'How can I say it in a just and correct way?'
P. I don't want to accuse my mother that it is her fault that . . . No way.
A. So it was a conflict 'How can I say it without saying too much or too little?'
P. Yes. How can I say it without it sounding too negative.
A. How did you feel in this dilemma?
P. As I said, Mr *A* did not ask any further at that moment, later he asked again. I found the explanation which I provided good.
A. And the emotions were not disturbing you?
P. No.

Video self-confrontation interview (VS-CI) with the patient, segment (1)

The following text represents the cognitions and emotions the patient recalled in the self-confrontation interview as occurring during the interview with the psychotherapist. The codes or categories were derived from the concepts of the theory of goal directed action described and referred to above:

- *Attempt*: Describe briefly what the situation was before it happened.
- *Emotion*: Feeling good.
- *Expectation*: Expected this question. It is not surprising.

- *Consideration of an alternative*: Should I mention this thing with my mother ... it is simply a bit difficult to explain, the thing about criticizing and so on. I don't want to blame my mother. She really tried her best.
- *Plan*: It is necessary to [to put it forward] ... the situation was like that, it was unusual that I was arguing with my mother.
- *Negative goal*: I don't want to accuse my mother that it is her fault. No way.
- *Strategy*: How can I say it without sounding too negative.
- *Interactive action step*: He is not asking any further...
- *Evaluation*: This explanation of mine is good.

Video self-confrontation interview provided additional suicide-related information

She (my mother) really tried her best.

It also indicates how important it was for the patient not to blame her mother.

Comment

The self-confrontation interview provided additional information about the suicide project and suicide career in this case closely intertwined with the mother–daughter relationship career. While the interview shows the patient being annoyed with her mother, the self confrontation reveals that she recognizes the goodwill of her mother and that she does not want to blame her for what happened and how important it is for her that others will not understand her suicide narratives as if she is trying to blame her mother.

Already the first interview segment indicates how much the patient is engaged in steering the course of the interview, that she has a concept of this interview and she evaluates whether the psychiatrist complies with her expectations or not. She considers, evaluates and chooses alternative steps in the interview, indicates her plan and strategy of her contribution to the interview, is very much aware of what the psychiatrist is or should be doing and also interprets the psychiatrist's actions as an indicator about how successful her own action was.

Interview, segment (2)

P. At that time, unfortunately, it came out very blunt.
A. And afterwards?
P. Afterwards she went and I had, logically, a bad conscience, one may not put it forward in such a way. I knew that I hurt my mother very much. I knew that I inflicted even more suffering on her. It was a pain for me and I simply wanted to know whether there is a possibility to stop this pain. And I was listless, for months I had been crying and now even this; she meant well. I did not see any way out. I could not go any further.
A. And what did you do afterwards?
P. Afterwards I went to the bathroom.

Video self-confrontation interview with the patient, segment (2)

- *Expectation of interactive action steps*: The next question should come; he will ask me questions.
- *Interactive intention*: I want to keep it short so that he can ask all the necessary questions. It is an interview.
- *Strategy/evaluation of an action alternative*: I should say [but I don't have the time] a lot about [my] upbringing and that I like my mother very much and that I don't wrap up my criticism well just because I have to but because I also don't want to hurt her. This developed over the years. It is because I am the only one my mother has as a family, I am all my mother has.
- *Plan/intention*: Try to be brief and summarize.
- *Evaluation*: The summary is good.
- *Strategy/evaluation of an action alternative*: It actually is here irrelevant how I was brought up and the ideals my mother had in bringing me up. It does not play such a big role here and if it does then just on the fringe.

VS-CI provided additional suicide-related information in segment (2)

I like my mother very much and I don't wrap up my criticism well just because I have to but because I also don't want to hurt her. This developed over the years. It is because I am the only one my mother has as a family, I am all my mother has.

Comment

As the patient was describing her feeling of having a bad conscience because of hurting her mother she discloses in the self-confrontation interview that these feelings are so intensive because of her liking her mother and because of her awareness of mother's emotional dependency on her. She also summarized a long-term development in their relationship.

The patient indicated in the self-confrontation interview a series of cognitions related to the joint action of the interview. She reported her expectation of interactive action steps of the psychiatrist, her interactive intention, her intention to help the psychiatrist with his interview, her evaluations of various action alternatives showing that she possesses a strategy for this interview, her intention, plan and finally evaluation of her own action.

Interview, segment (3)

Where I kept normal razor blades and I looked at them and thought whether it would hurt if you cut yourself. Afterwards I tried it; first on the upper arm and at all strategical places and it did not hurt at all.

A. With the razor blades which come in plastic?
P. They are razor blades to put into a razor.
A. Double blades?

P. Exactly, but one can break them, that's what I did. It doesn't look appetizing but it works well and then I tried at first here [upper lower arm] and it did not hurt. Then I watched how it bled and it was nothing special. And then I cut myself at the strategic places [wrist]. . .

Video self-confrontation interview with the patient, segment (3)

- *Thinking/evaluating task demand*: Difficult to describe what I felt in the bathroom.
- *Intention of identity related strategy*: Try to explain to him everything in such a way that it does not sound schizophrenic.
- *Evaluation*: It is difficult.
- *Thinking about convention*: Many people can't imagine that it does not hurt and that one is not anxious at that moment.
- *Attempt*: Explain what happened in the bathroom.
- *Cognition of interactive steering*: Psychiatrist interrupts me.
- *Thinking*: Continue with explanation.
- *Thinking/value*: It is important for me to explain exactly what happened.
- *Thinking/evaluating task demand*: It is difficult to explain it.
- *Attempt*: Find the right words.
- *Thinking about interviewer's evaluation of owns action step*: Hopefully it is enough in a 'matter of fact' manner.
- *Intention/strategy*: Attempt to explain in a matter of fact manner that it does not hurt and that one is not crazy even if it does not hurt.

VS-CI provided additional suicide-related information in segment (3)

> I felt out of myself and I know that it sounds crazy, schizophrenic, and it fits DSM and I don't want to be taken for schizophrenic. There was a difference compared to the first cuts which I made to myself, these were more or less from interest. I began to put myself out of my body because of the sorrow. I really watched myself. The last cut I did was really deep.

Comment

While the patient described in the interview what happened the information how she felt and what she thought has been provided only in the consecutive video self-confrontation interview. This was a key experience which the patient is anxious to tell in such a way that her mental health is not questioned. It gives information about her difficult task in the interview with regard to her identity management. Additionally, this information provides an explanation of why a self harming action is not prevented by the fear of pain. The patient also described a series of cognitive processes related to interactive and joint action. She also evaluates the task, has a clear goal and considers strategies.

Interview, segment (4)

> . . .and put the arm into water and watched the rings, which was pretty. I was more or less simply watching myself. In the previous months I drew boundaries, watched myself often and did the same then (during the suicide attempt).

A. As you are telling this it sounds as if you were separated from your feelings.
P. Yes, completely. I was watching myself even then, I know it sounds schizophrenic but it was like that 'it is simply bleeding now'. And then I cut again. Before that I cut three times and then another time.
A. Here where the veins are?
P. Yes, this one here. And then suddenly it did not look nice and I knew that I cut deep enough. Then I became frightened.

Video self-confrontation interview with the patient, segment (4):

- *Assessment of emotional demands*: It is emotionally strenuous.
- *Strategy*: I have to find the right words.
- *Knowledge of social convention*: I know that it sounds crazy. It sounds ridiculous if someone says 'I am standing outside myself and I am watching myself'. It is not the normal case.
- *Plan*: I have to tell it all.
- *Attempt*: Try to convey it.
- *Negative goal*: Do not want it to sound schizophrenic.
- *Feeling*: It is strenuous.

Suicide-related information from self confrontation, segment (4)

> . . .Also the selective perception that this really exists. I was really surprised. I mean, I have read enough about it so that I know that it really exists. What I've realized in general is that people are afraid of death and of talking about death. Everything related to death is taboo. One can't even say that one is not afraid of death. If someone says one is not afraid of death then one is already seen as a potential suicide candidate. Even if one does not think about it. Alone the fact that one is not afraid . . . leads to not speaking about it, well I don't.

Comment

The information on how emotionally strenuous the interview is, is provided only in the consecutive video self-confrontation interview. The patient indicates the fight and dilemma she found herself in during the interview trying to say everything while also trying to preserve her desired identity and avoid the attribution of mental illness. She reports a goal, plan, strategy as well as consideration of social conventions. Additionally, she discloses her opinion about death and her anxiety of having a suicide career or project attributed to.

Finally, in the video self-confrontation interview the patient rephrases some of the description she provided during the interview with the psychiatrist:

> The anxiety came then really after the last cut. I also reacted differently than to the other cuts. With the other one I was watching, it was pretty and there were little rings. But then I really became frightened and astonished. I was actually astonished that I was frightened. I was sure that I am not afraid of death, but probably I am.

Interview, segment (5)

> . . .and I was not outside of myself any more.

A. You were what?
P. Not outside of myself anymore. And it was this last deep cut and it really did not look nice any more and I knew if I did not do anything I would die. As stupid as it sounds.
A. It is clear.
P. Then I put a compression on it and went to the telephone and called my mother and asked her to forgive me and said that I was sorry and she should help me. And my mother was somehow expecting it.
A. Did you tell her what you had done?
P. Yes I said she should help me and that I am bleeding and I am afraid of dying. And my mother said I should stop talking as she wants to make a call. Then she put the receiver down and called the police. I began running like a wild animal in a circle in my room, in the working room.

Video self-confrontation interview with the patient, segment (5):

- *Recall*: Remember the episode where I am calling [my mother].
- *Monitoring of bodily sensation*: Becoming red in the face.
- *Emotion*: The feelings [from the suicide episode] come up. I feel the fear. It is fear of death.
- *Emotion*: I feel the fear. [It is the fear from the time when I was on the telephone to my mother.]
- *Recall*: Telephoning with my mother it was not important that I've hurt her. She was on the quick dial, it was the quickest number I had, and she should do something and if it is too late she should know that I am afraid. I was dizzy and wanted to run away.

Suicide-related information from self confrontation, segment (5)

> After the telephone, my mother put the receiver down, I did not know what to do. I ran like a wild animal in a circle because I had the feeling I mustn't stand still. And I went to open the door, actually to check the door whether it is open and it was open. It was really bad.
>
> Primarily it was the feeling of anxiety. Telephoning with my mother it wasn't important any more that I had hurt her. This was not important. She was on the

> quick dial on the phone and she was the quickest number I had and she should do something and if it was too late she should know that I was afraid. As I had it on quick dial I only had to press a button. I felt dizzy. I felt like running away from myself.

Comment

The patient described a clear recall during the interview of a critical, emotionally experienced episode in her suicide action. Further, she described a bodily sensation of becoming red in her face and, finally, her emotions which were the emotions she had during the self-harming action. Additionally, she provided a number of details about the suicide action which she did not mention during the interview with the psychiatrist.

Finally, the patient used the self-confrontation interview for rephrasing the crucial point of the interview in this segment:

> I was sure that I cut deep enough. I knew at that moment that it was wrong. The fact that it was wrong does not change anything about the fact that one is bleeding. And I was so afraid that I would not manage and did not know what to do. I was really frightened.

Interview, segment (6)

> . . .always in circle, just like a bloated horse. I just did not want to die. Then she rang again and said I should not worry and that someone is coming.

A. Was it still bleeding or did it stop after the compressure?
P. It stopped afterwards. I put the compressure on quite well. I could hardly take it off afterwards. And then the police came and picked me up. They put something on my arm. Afterwards I was taken to the hospital. It was stitched there. Everything is actually very positive after all.
A. Is it true? I would appreciate your telling me what you mean by that.
P. It was very positive. I went afterwards to my mother's flat. She came to pick me up from the hospital, actually, a colleague from work drove her as she did not want to drive herself. She picked me up and I stayed with her over the weekend.

Video self-confrontation interview with the patient, segment (6)

> *Feeling*: Feeling better while remembering feeling better when the police came.
> *Feeling*: Also feeling better because the interview continues.
> *Attempt*: Trying to suppress the anxiety as I am still anxious about dying.
> *Feeling*: I am relieved.

Suicide-related information from the video self-confrontation interview, segment (6)

> I was relieved when the police came and they were really nice.
> It was the absolute relief.

> Well, I don't have nightmares or such feelings but perhaps I am afraid, that if I die once . . . I hope that it will not hurt or at least that I die in such a way that I'll not have the feeling: it has to be now.

Comment

As she partly re-experienced the fear of dying during the video self-confrontation interview in the previous segment the patient also re-experienced the relief of being saved. Additionally, she felt well because of the course of the interview. Finally, she provided more information about her feelings during the part of the suicide action where she was recovered by the police. She also disclosed information about her emotional state now after the suicide attempt and what she learned about dying.

Interview, segment (7)

P. Sunday and Monday. We were able to talk together extremely well and I told her that I had an extremely bad conscience, not only because what I did [suicide attempt] but because I told her all these things and I did not know how to apologize. I was very sorry and she did understand. She really understood. She actually had also tried it [commit suicide] herself which I did not know.
A. Really?
P. She had cut herself as well.
A. And you did not know about it.
P. No, I did not know about it.
A. Did she say how old she was at that time?
P. She was older then. I assume in her early 30s. A man had left her as well, a similar situation. I told her she must not say anything to him [my ex-boyfriend].

Video self-confrontation interview with the patient, segment (7)

- *Assessing an action alternative*: Can I talk about it as it is a private matter of my mother. I know that she told the man who left her. I do not want that it sounds like stereotype 'you left me and I am going to kill myself'. I did not cut myself in order to blackmail him. I don't want him to know as it is my private matter.
- *Considering a strategy*: Can I tell it as it is a private matter of my mother but it explains why she understood.
- *Thinking*: Can I tell it.
- *Remembering*: I was told that nobody will get to know what I say here.
- *Thinking*: Can I tell it?
- *Plan*: Yes I tell it in order to make it more plausible.

Suicide-related information from the video self-confrontation interview, segment (7)

> I know that she told her friend then, who left her.

I did not cut myself because I wanted to blackmail him. I don't want him to know about it as it is my own private matter.

Comment

In addition to the interview the video self-confrontation interview provided insight into the patient's difficult decision-making whether or not to disclose the information about the suicide attempt of her mother. She evaluated several reasons for and against it. The importance she ascribed to delivering the story of her suicide attempt in such a way that it mirrors her understanding of it is underlined. Additionally, she described how she wants to treat the information about her suicide attempt in regard to her boyfriend.

Interview, segment (8)

A. Do you still see it as also having beneficial consequences?
P. Yes, very much so.
A. Even now, more than 1 month later?
P. Yes there were very positive consequences. Obviously, nothing changed as far [as love sickness is concerned].
A. Nothing?
P. No.
A. You did not do it just because of the love sickness but the last push came from your mother. That was the important trigger. If your mother had not come to see you, you would not have done that.
P. I don't know. Perhaps it would have been somehow different. The original situation was that he left me and I did not know why. And he did not give me any explanation. And I constructed scary theories about disposable humans used just for one purpose and humans who don't have any value and one can do it to them. Prostitutes have certain advantage . . .

Video self-confrontation interview with the patient, segment (8)

- *Evaluating of interactive response*: Dr *A* did not understand. He thinks, it is my mother's fault.
- *Cognition of the reason*: But it was altogether not just the argument as I had an argument with her for many times before. It was just different than the other times.
- *Evaluation of interactive actions*: Have the feeling that it [understanding of the episode] goes the wrong way.
- *Considering of plan*: How to repair that.
- *Goal*: I want to put the story right.
- *Plan*: Explain again that there were more things and not just this argument.
- *Value*: It is important to put the story right.
- *Expectation*: It will give the wrong impression.
- *Assessment*: It is a wrong picture. A mother–daughter argument. It was partly the case but it was rooted in something else: 'I can't help you, I'd like to help you and I know it'.

I know that she tries but sometimes it just is not the right thing what she does. I don't know myself what is right.

Suicide-related information from the video self-confrontation interview, segment (8)

It was everything together and not just the argument as I had *x* arguments with my mother. It was different from the other times. And the other times belong to it as well.

A mother–daughter argument. It was partly the case but it was rooted in something else: 'I can't help you, I'd like to help you and I know it'. I know that she tries but sometimes it just is not the right thing what she does. I don't know myself what is right.

Comment

It is striking how important the patient considers that the psychiatrist understands her story in the way she is trying to convey. Additionally, there also is a discrepancy between her response to the misunderstanding in her eyes during the interview and in her subjective view she disclosed in the video self-confrontation interview. The patient also provides a clear insight into her action-related thinking in that she provides the evaluation of the wrong answers of the interviewer, the reason why it is wrong, her goal to repair the understanding, plan for doing it and a value why she wants to do it.

Finally, she again describes the suicide preceding developments, thus clarifying the suicide career in the way as she understands it.

Discussion

This article is intended to underline the special tasks of an interview with a suicide attempter, to present an interview technique considered helpful in overcoming the problems of the conventional interview and, finally, to show what additional information can be gained in conducting the video self-confrontation interview in addition to the psychotherapeutic interview. Although the presented excerpt of one interview stems from a research project in which 30 interviews were performed, it is a single case study and thus any generalizations must be taken with care. And indeed a preliminary survey of our interviews shows that they are all very different as the patients are at different stages of their life, different stages of their suicide career, have different competencies such as eloquence, differentiation and insight. However, there are also certain features which are comparable and which will be elaborated upon further.

A video self-confrontation interview provides a substantial amount of additional information. It reveals more about the suicide action and development, it addresses the cognitions and emotions the patients have during the interview which are related to the course of the interview and, finally, not pronounced in this case, the patients address changes the self-confrontation interview induced in their feeling and thinking.

The additional information about the suicide act often refers to emotions while the interview tends to address the individual steps of the suicide action. This may perhaps be related to the conception of the rational suicide (Werth and Cobia, 1995). The VS-CI also provides reasoning and more information about preceding development. Most importantly, the VS-CI discloses cognitive and emotional processes related to the interview, whereas the interview itself does not reveal anything other than what the interviewer can infer through observation of nonverbal behaviour. It indicates whether the patient is satisfied or not with the course of interview, the emotions the patient has, the decisions the patient makes etc. Additionally, the video self-confrontation reveals that patients approach the interview with the psychiatrist/psychotherapist with a certain conception and expectation, they set themselves goals, consider strategies and make plans of how to go about achieving these goals, make assessment, evaluations, refer to values, make decisions, consider action alternatives, etc. These concepts are action concepts described in action theories (Valach *et al.*, in press; von Cranach *et al.*, 1982). Actions are seen as goal directed processes, intentional, planned, energized and monitored. They are cognitively and socially steered and controlled as well as subconsciously regulated. Their systemic organization contains a hierarchy of supra ordination of goals, subordination of sub-goals and action steps which are superordinated to action elements. Actions are also organized in sequences. It is this action conceptualization that the patients indicate in their reports on their cognitions and emotions during the interview. However, individual action as a model system for an interview is only half of the matter. As indicated in the introduction the patient—psychotherapist/psychiatrist interview is also a joint action. The quoted example above provides documentation on a number of interactive and partner related cognitions. These are part of the joint action processes. The patient indicates her willingness to participate in the interview action, is open to set up a goal of the interview and is eager to participate in the order of the interview. There are moments where the patient is ready to adopt the tasks the interviewer provides and other moments where the patient wants to give an interpretation she sets as a goal for this joint action. However, the patient does not measure the success of her contribution on the similarity to her recall of events, but also on the responses the interviewer shows. The attempt to gain a joint understanding is salient. The contribution of the patient to the joint process of interview becomes also transparent in the expectations the patient has about the action of the psychiatrist/psychotherapist.

It is maintained here that a psychologist/psychiatrist interview with a patient after suicide can gain much by both adopting this procedure and using this conceptualization of an interview. It is clear that there is much more in the mind of the patient than is verbalized in the interview. On the other hand, there is much satisfaction being derived from a consistent story the patient can deliver and construct together with the interviewer. Using the terms of action as explained in the theory of goal directed action, the action conceptualization as seen in the patient's thinking during the interview can be used in further reasoning as well as in the organization of the interview. It becomes more than just everyday thinking not integrated into a theory of human behaviour. Further, it has to be accepted that as much as the patients enter an interview with everyday concepts they also enter it with clear ideas of what it is all about, how they want to come out of it, etc. This is expressed in expectations, intentions, goals, plans, strategies, assessment, evaluation,

decisions etc. Consequently, a successful and collaborative interview must account for all of them. Just as the psychiatrist/psychotherapist has the skills of conducting or taking a good interview the patient has the techniques to give a good interview. However, the training of the therapist for an interview must include the knowledge that these two processes will be integrated into one process of an interview in which neither of them is the only instigator that sets the goals, decides, steers and controls the course of the interview.

References

ANDREW, S.A. (1993) TV: not just a boob tube anymore. *Journal of Mental Health Counseling*, *15*, 206–212.

BREUER, F. (1995) Das Selbstkonfrontations-Interview als Forschungsmethode (The research method of the self-confrontation interview). In E. Koenig & P. Zedler (eds) *Bilanz qualitativer Forschung. Band II: Methoden* (pp. 159–180). Weinheim: Deutscher Studien Verlag.

CHOQUET, M. & MENKE, H. (1989) Suicidal thoughts during early adolescence: prevalence, associated troubles and help-seeking behaviour. *Acta Psychiatrica Scandinavica*, *81*, 170–177.

CULP, A.M., CLYMAN, M.M. & CULP, R.E. (1995) Adolescent depressed mood, reports of suicide attempts, and asking for help. *Adolescence*, *30*, 120, 827–837.

DAITZMAN, R.J. (1977) Methods of self-confrontation in family therapy. *Journal of Marital and Family Therapy*, *3*(4), 3–9.

DOERR, H.O. & CARR, J.E. (1982) Videotape 'self-confrontation effect' as function of person viewed and task performed. *Perceptual and Motor Skills*, *54*(2), 419–433.

DOLLARD, J., DOOB, L.W., MILLER, N.E., MOWRER, O.H. & SEARS, R.R. (1939) *Frustration and aggression*. New Haven, CN: Yale University Press.

DOWRICK, P.W. (1991) *Practical guide to using video in the behavioural sciences*. New York: John Wiley & Sons.

FULLER, F.F. & MANNING, B.A. (1973) Self-confrontation reviewed: a conceptualization for video playback in teacher education. *Review of Educational Research*, *43*, 469–528.

GIBBONS, F.X., SMITH, T.W., INGRAM, R.E., PEARCE, K., BREHM, S.S. & SCHROEDER, D.J. (1985) Self-awareness and self-confrontation: Effects of self-focused attention on members of a clinical population. *Journal of Personality and Social Psychology*, *48*, 662–675.

GRUBE, J.W., MAYTON, D.M. & BALL-ROKEACH, S.J. (1994) Inducing change in values, attitudes, and behaviours: belief system theory and the method of value self-confrontation. *Journal of Social Issues*, *50*(4), 153–173.

HAWTON, K. & BLACKSTOCK, E. (1976) General practice aspects of self-poisoning and self-injury. *Psychological Medicine*, *6*, 571–575.

HAWTON, K., KINGSBURY, S., STEINHARDT, K., JAMES, A. & FAGG, J. (1999) Repetition of deliberate self-harm by adolescents: the role of psychological factors. *Journal of Adolescence*, *22*(3), 369–378.

HERMANS, H.J. (1992) Unhappy self-esteem: a meaningful exception to the rule. *Journal of Psychology*, *126*, 555–570.

HERMAN, J.L. (1993) *Trauma and recovery*. New York: Basic Books.

HERMANS, H.J.M. & HERMANS-JANSEN, E. (1995) *Self-narratives: the construction of meaning in psychotherapy*. New York: Guilford Press.

HERMANS, H.J.M. & OLES, P.K. (1994) The personal meaning of values in a rapidly changing society. *Journal of Social Psychology*, *134*, 569–579.

HERMANS, H.J.M. & OLES, P.K. (1996) Value crisis: affective organization of personal meanings. *Journal of Research in Personality*, *30*, 457–482.

HERMANS, H.J., FIDDELAERS, R., DE-GROOT, R. & NAUTA, J.F. (1990) Self-confrontation as a method for assessment and intervention in counseling. *Journal of Counselling and Development*, *69*, 156–162.

ISOMETSÄ, E.T., HEIKKINEN, M.E., MARTTUNEN, M.J., HENRIKSON, M.M., ARO, H.M. & LÖNNQVIST, J.K. (1995) The last appointment before suicide: is suicide intent communicated? *American Journal of Psychiatry*, *152*, 919–922.

KAGAN, N. (1978) Interpersonal process recall: Media in clinical and human interaction supervision. In M.M. Berger (ed.) *Videotape techniques in psychiatric training and treatment* (2nd ed.) (pp. 70–84). New York: Brunner/Mazel.

KAGAN, N., KRATHWOHL, D.R. & MILLER, R. (1963) Stimulated recall in therapy using videotape—a case study. *Journal of Counselling Psychology*, *10*, 237–243.

KAHN, G.S., COHEN, B. & JASON, H. (1979) The teaching of interpersonal skills in the US medical schools. *Journal of Medical Education*, *54*, 29–35.

KALBERMATTEN, U. & VALACH, L. (1985) Methods of an integrative approach for the study of social interaction. *Communication and Cognition*, *18*, 281–315.

KAPLAN, M.L., ASNIS, G.M., SANDERSON, W.C., KESWANI, L. *et al.* (1994) Suicide assessment: clinical interview vs self-report. *Journal of Clinical Psychology*, *50*, 294–298.

KIENHORST, I.C.W.M., DE WILDE, E.J., DIEKSTRA, R.F.W. & WOLTERS, W.H.G. (1995) Adolescents' image of their suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry*, *34*, 623–628.

MCGAUGHEY, J., LONG, A. & HARRISSON, S. (1995) Suicide and parasuicide: a selected review of the literature. *Journal of Psychiatry and Mental Health Nursing*, *2*(4), 199–206.

MICHEL, K. (1986) Suizide und Suizidversuche: Könnte der Arzt mehr tun? (Suicide and suicide attempt. Could a physician do more?). *Schweizerische medizinische Wochenschrift*, *116*, 770–774.

MICHEL, K. & VALACH, L. (1996) *Interview with suicide attempters: an action theoretical approach. A research proposal*. Berne: Swiss National Research Foundation.

MICHEL, K. & VALACH, L. (1997) Suicide as goal directed action. *Archives of Suicide Research*, *3*, 213–221.

MICHEL, K., VALACH, L. & WAEBER, V. (1994) Understanding deliberate self-harm: the patients' views. *Crisis*, *15*, 172–178.

MICHEL, K., RUNESON, B., VALACH, L. & WASSERMAN, D. (1997) Contacts of suicide attempters with GPs prior to the event: a comparison between Stockholm and Bern. *Acta Psychiatrica Scandinavica*, *95*, 94–99.

MÖLLER, H.J. (1990) Evaluation of aftercare strategies. In G. Ferrari, M. Bellini, P. Crepet (Eds.), *Suicidal behaviour and risk factors* (pp. 39-44). Bologna: Monduzzi Editore.

MURPHY, G.E. (1975) The physician's responsibility for suicide. I. An error of commission; II. Errors of omission. *Annals of Internal Medicine*, *82*, 305–309.

ÖJEHAGEN, A., REGNELL, G. & TRÄSKMAN-BENDZ, L. (1991) Deliberate self-poisoning: repeaters and nonrepeaters admitted to an intensive care unit. *Acta Psychiatrica Scandinavica*, *84*, 266–271.

PETRIE, K. & ABELL, W. (1994) Responses of parasuicides to a computerized interview. *Computers in Human Behaviour*, *10*, 415–418.

RONGE, J. & KUEGELGEN, B. (ed.) (1993) *Perspektiven des Videos in der klinischen Psychiatrie und Psychotherapie (Perspectives of video-usage in clinical psychiatry and psychotherapy)*. Berlin: Springer.

SANBORN, D.E., PYKE, H.F. & SANBORN, CH. J. (1975) Videotape playback and psychotherapy: a review. *Psychotherapy Theory, Research and Practice*, *12*, 179–186.

SCHWARTZ, S.H. & INBAR-SABAN, N. (1988) Value self-confrontation as a method to aid in weight loss. *Journal of Personality and Social Psychology*, *54*, 396–404.

TREOLAR, A.J. & PINFOLD, T.J. (1993) Deliberate self-harm, an assessment of patients' attitudes to the care they receive. *Crisis*, *14*(2), 83–89.

VALACH, L. (1990). A theory of goal-directed action in career analysis. In R.A. Young & W.A. Borgen (eds) *Methodological approaches to the study of career* (pp. 107–127). New York: Praeger Publishers.

VALACH, L. & KALBERMATTEN, U. (1986). Videorückmeldung und die Prozesse des Individual- und Gruppenhandelns (Video feedback and the processes of individual and group action). In W. Langthaler & H.Schneider (eds) *Video-Rückmeldung und Verhaltenstraining (Video feedback and behavioural training)*. Münster: MAKS Publikation.

VALACH, L., YOUNG, R. A. & LYNAM, J. (1996) The family's health promotion project. *Journal of Health Psychology*, *1*(1), 49–63.

VALACH, L., YOUNG, R.A. & LYNAM, M.J. (in press) *Action theory primer for applied research in the social sciences*. New York: Praeger.

VANDEREYCKEN, W., PROBST, M. & VAN BELLINGHEN, M. (1992) Treating the distorted body experience of anorexia nervosa patients. 5th Congress of the International Association for Adolescent Health (1991, Montreux, Switzerland). *Journal of Adolescent Health*, *13*, 403–405.

VAN HEERINGEN, C., JANNES, S., BUYLAERT, W., HENDERICK, H., DE BACQUER, D. & VAN REMOORTEL, J. (1995) The management of non-compliance with referral to out-patient after-care among attempted suicide patients: a controlled intervention study. *Psychological Medicine*, *25*, 5, 963–970.

VON CRANACH, M. & VALACH, L. (1986) Action theory. In R. Harré & R. Lamb (eds) *The dictionary of personality and social psychology*. Oxford: Blackwell Reference.

VON CRANACH, M., OCHSENBEIN, G. & VALACH, L. (1986) The group as a self active system: outline of a theory of a group action. *European Journal of Social Psychology*, *16*, 193–229.

VON CRANACH, M., KALBERMATTEN, U., INDERMUEHLER, K. & GUGLER, B. (1982) *Goal directed action*. London: Academic Press.

WERTH, J.L. Jr & COBIA, D.C. (1995) Empirically based criteria for rational suicide: a survey of psychotherapists. *Suicide & Life Threatening Behaviour*, *25*, 231–240.

WOLK-WASSERMAN, D. (1987) Contacts of suicidal neurotic and prepsychotic/psychotic patients and their significant others with public care institutions before the suicide attempt. *Acta Psychiatrica Scandinavica*, *75*, 358–372.

YOUNG, R.A., PASELUIKHO, M.A. & VALACH, L. (1997) The role of emotion in the construction of career in parent-adolescent conversation. *Journal of Counselling and Development*, *76*, 36–44.

YOUNG, R.A., VALACH, L. & COLLIN, A. (1996) A contextualist approach to career analysis and counselling. In D. Brown & L. Brooks (ed.) *Career choice and development* (3rd ed.) (pp. 477–512). San Francisco, CA: Jossey-Bass.

YOUNG, R.A.,Valach, L., DILLABOUGH, J.-A., DOVER, C. & MATTHES, G. (1994). Career research from an action perspective: the self-confrontation procedure. *Career Development Quarterly*, *43*, 185–196.

YOUNG, R.A., VALACH, L., PASELUIKHO, M.A., DOVER, C., MATTHES, G.E., PAPROSKI, D. & SANKEY, A. (1997) The joint action of parents and adolescents in conversation about career. *The Career Development Quarterly*, *46*, 72–86.

ZEIGARNIK, B. (1927) Das Behalten erledigter und unerledigter Handlungen (Retaining of finished and unfinished actions). *Psychologische Forschung*, *9*, 1–85.