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THE NARRATIVE INTERVIEW WITH THE SUICIDAL PATIENT

KONRAD MICHEL AND LADISLAV VALACH

When we are able to formulate the right story, and it is heard in the right way by the right listener, we are able to deal more effectively with the experience.

—Adler (1997, p. 28)

Most psychological problems have a personal and often complex history. This is particularly true for suicidal behavior. Suicide and attempted suicide reflect patients' abject inability to cope with a serious emotional problem. It is emblematic of the incapacity to deal with certain psychological and biographical factors. Outside observers can always interpret the behavior from their own perspective, but they will not be able to understand the crucial individual context behind a person's suicidality without the active help of the patient.

Only when the story behind an act of self-harm can be fully shared with another person can there be a common ground for a therapeutic relationship (whether this be in an inpatient or outpatient setting). Even when perceptions of the present situation and the self are colored by depressed mood and cognitions, individuals who survive a suicide attempt usually have a remarkably good narrative competence—if the interviewer is prepared to assume an open, nonjudgmental, and supportive therapeutic attitude.

Narrative interviewing has been a core element of the Aeschi philosophy right from the beginning. It was originally a spinoff from a study on interviewing patients who had attempted suicide, carried out in Bern, Switzerland (Michel, Dey, Stadler, & Valach, 2004). In this study, we found that the patients'

evaluation of the therapeutic relationship was significantly better when the interviewer opened the interview with a narrative opening (e.g., “I would like you to tell me the story behind it”). When, in the first meeting of clinical experts (the later Aeschi Working Group), videorecorded interviews made in the course of this study were discussed, it was obvious to everyone that “bad” interviewers tended to adhere to a medical model to interpret patients’ behavior and inner experience, whereas “good” interviewers encouraged patients to simply tell them their story. Patients had been given the Penn Helping Alliance Questionnaire (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982) to rate the quality of the therapeutic relationship. When interviews with high and low scores were compared in a careful transcript analysis, it emerged that bad interviews were characterized by clinician domination and question–answer interactions, whereas in good interviews the interviewer was empathic, attentive, and nonjudgmental, leaving sufficient room for patients to provide their own account of what happened (Frei, Grimmer, Michel, Valach, & Boothe, 2010).

This chapter first takes a critical look at patterns of communication between suicidal patients and health professionals, particularly focusing on the traditional medical model and its impact on the patient–clinician interaction. This is followed by considerations about the virtue and clinical importance of suicidal storytelling. An issue that needs special attention is how clinicians can combine two very different roles: (a) the role of the facilitator of the patient’s story, where the patient is the expert (of his or her story); and (b) the role of the clinical expert, whose task it is to assess the patient’s mental state, make a diagnosis, and decide on adequate treatment and management of the patient. A case example with a verbatim interview illustrates the narrative approach to the suicidal patient.

SUICIDAL PLANS ARE OFTEN NOT COMMUNICATED

In a seminar, a general practitioner from a rural practice shared the following story. On a busy Saturday morning in his practice, a 45-year-old teacher whom he had not seen for 2 years presented with a strained left ankle. The patient told him that “it happened a couple of days ago when I went for a walk in the forest.” The doctor could not find anything remarkable, and he discharged the patient with some ointment and an elastic bandage. Two hours later the patient’s wife called to ask whether her husband was still at the practice, as he had not returned yet. She called again an hour later, reporting that her husband had been found dead in the forest. He had shot himself through his head.

The story illustrates a typical problem in suicide prevention: Suicidal persons, particularly men, even if they are under medical care, rarely talk about their intentions. Indeed, more than one third of individuals who die by suicide have seen a general practitioner or a medical specialist within a month before their death, with some 20% in the week before death (Pirkis & Burgess, 1998). In a psychological autopsy study of 571 suicides in Finland, all of whom had contacted a health care professional prior to their death, Isometsä et al. (1995) found that at the last visit the issue of suicide had been discussed in only 22% of the cases (39% in psychiatric consultation, 11% in general practice, and 6% in another medical consultation). Furthermore, the frequency of contacts with primary care increased prior to suicide and attempted suicide (Appleby, Amos, Doyle, Tommenson, & Woodman, 1996; Michel, Runeson, Valach, & Wasserman, 1997), suggesting that the reasons for the visits to health professionals are related to the development of a suicidal crisis. In fact, as in the introductory example, it is not at all rare that patients see a health professional only a few hours before dying by suicide. In the Finnish study, 18% of those who had contacted a physician had done so on the day of their suicide, yet even then the issue of suicide was discussed in only one fifth of these cases. Therefore, undeniably, there is a problem of communication between suicidal patients and health professionals. This communication problem affects not only prevention but also aftercare of suicide attempters.

When the round of family doctors was asked if they had any suggestions for what else their colleague could have done, one of them said, "Maybe in such situations we should try to move away from 'just medical' talk and probe for psychosocial problems, for instance by asking: 'And how are things at home?'" This, in fact, is a conclusion that can be taken from a study by Goldberg, Jenkins, Millar, and Faragher (1993). Goldberg et al. found that *cue emission*, that is, the rate at which patients emit signs that are indicative of psychological distress, largely depended on the interviewing style. Asking physical questions and asking questions derived from theoretical knowledge (i.e., doctor led) both decreased cue emissions; the same was true for directive or closed social and psychological questions. What was found to be helpful were interviewers who showed interest and concern for the patient, and, particularly, interviews that were patient led. Similarly, Bertakis, Roter, and Putnam (1991) reported that patients' satisfaction was higher with interviews that encouraged them to talk about psychosocial issues in an atmosphere that was characterized by the absence of physician domination. It is interesting to note that half of the variation of the interviewers' accuracy to detect psychological disturbance appears to depend on the first few minutes of an interview (Goldberg & Huxley, 1980).

THE MEDICAL MODEL AND SOME OF ITS PROBLEMS

In modern medicine, there is a danger of a mismatch between descriptive diagnosis and the lived experience of illness. Techniques of clinical evaluation that focus on symptoms of present illness, past history, family history, and so forth, can often leave little room to “discover” the person (Strauss, 1994).

In the assessment of the risk of suicide, the traditional medical model heavily depends on a risk-factor approach. Clinical risk factors for suicide have been established in numerous studies. The classical retrospective investigations by Barraclough, Bunch, Nelson, and Sainsbury (1974), Robins (1981), and others (e.g., Conwell et al., 1996) confirmed that the vast majority—in fact over 90%—of adults who die by suicide fulfill the criteria of a psychiatric diagnosis. The same applies to persons who are making serious suicide attempts (Beautrais et al., 1996). The most frequent diagnosis found in retrospective studies of consecutive cases of suicide is major depression (between 40% and 60% of the cases). The proportion of depressed patients who are under medical care is likely to be higher than in unselected suicides. In the Finnish study (Isometsä et al., 1995), depression was reported to have been present in 75% of those patients who had seen a physician within the 4 weeks prior to committing suicide.

For decades, the prevention of suicide has been equated with the detection and treatment of depressive disorders. However, a diagnosis of depression, although a major risk factor for suicide, is a very poor predictor of actual suicidal behavior. In a study aimed at determining the generalizability and relative importance of risk factors for suicide acts across diagnostic boundaries, Mann, Waternaux, Haas, and Malone (1999) found that objective severity of current depression or psychosis did not distinguish the patients who had attempted suicide from those who had never attempted suicide. However, subjective depression, hopelessness, and suicidal ideation were greater in suicide attempters than in nonattempters, despite comparable rates of objective severity for depression or psychosis. Suicide attempters also scored lower on the Reasons for Living Inventory—a scale that has been considered to measure the protective effect of reasons for living (Linehan, Goodstein, Nielsen, & Chiles, 1983). These findings suggest that although the diagnostic evaluation is important, in fact a *sine qua non* of clinical evaluation, it contributes little to the prediction of suicidal behavior in the individual patient. In other words, among depressed patients suicide remains a rare event. Factors predictive of infrequent behavior often lead to large numbers of false-positive and false-negative cases and may give the wrong impression of scientific predictability (Pokorny, 1983). Identifying the—rare—patient with an acute risk of suicide seems rather like searching for the needle in the haystack, particularly considering that the average general practitioner has to expect a suicide of a patient every 3 to 5 years.

This does not mean that clinical risk factors for suicide can be neglected. Most psychiatric diagnoses are associated with an increased risk of suicide (Harris & Barraclough, 1997). In every clinical assessment of a suicidal patient, a careful evaluation of the signs and symptoms of psychiatric disorders is mandatory. Following a clinical diagnosis, adequate treatment needs to be implemented.

Exploring for clinical risk factors usually means that the interviewer applies a structured and mechanistic style of assessment, often firing questions at patients in regard to mental state, history of suicidal behavior, and so forth. Emergency room assessment interviews are notorious for moving quickly from the surface-level story (“What did you do?”) through an assessment of current risk (“Are you suicidal now?”) to disposition of the patient (“What is best for you now?”; Rogers & Soyka, 2004). Patients often feel impersonally processed, with little opportunity to contribute to any perspective on what actually lies behind the act of self-harm. Unfortunately, such a clinical approach may actually contribute to a patient’s suicidality. Rogers and Soyka (2004) argued that a one-size-fits-all approach actually serves to distance and marginalize suicidal patients and contributes to the lack of effectiveness of mental health professionals. The traditional medical intervention model, often in the form of crisis intervention, may serve to keep the person alive in the short term but may not allow the person to live in the long run. The crisis model “unambiguously creates a power imbalance placing the clinician in an expert, directing, and evaluative position” (Rogers & Soyka, 2004, p. 11), leaving little room for the patients to reestablish their lost sense of self-reliance. Thus, the medical model can be perceived as meeting the needs of the clinician rather than those of the client. The emphasis is on facts in contrast to the context and meaning of the patient’s suicidality, with the suicidal person’s story largely a taboo subject. As Rogers and Soyka (2004) noted,

the crisis intervention model is creating an illusion of competence that has served to stifle the development of alternative perspectives and approaches to working with suicidal individuals. Given the analysis, it may be understandable that our efforts have not translated empirically into a reduction in suicidal behavior. (p. 15)

So, health professionals who are called to see a patient who attempted suicide, are faced with a difficult task: On the one hand, they have to conduct a diagnostic interview to detect psychopathology, to develop a treatment plan, while on the other hand, they must be open to listen to the patient and to avoid a clinician-dominated interviewing style. The two roles can obviously conflict with each other. In the assessment of clinical pathology and the management of its treatment, the health professionals are the experts, based on their specialized training and clinical expertise. However, when the focus is on the patient’s story, the patients as individuals are the experts of their

stories. Only the patients “know” what led to the development of the suicidal urge and how this is related to their biography. In a response to the dynamics of the traditional medical model, the Aeschi Working Group argued that the active exploration of the mental status should *follow* an initial narrative approach (Michel et al., 2002; see the appendix to the Introduction of this volume, Aeschi Working Group: Guidelines for Clinicians).

ABOUT STORIES AND STORYTELLING

Storytelling is a deeply human capacity. *Narratives* are stories told to a listener. They represent a series of events and their associated meanings for the teller. Meaning is accomplished interactionally, between teller and listener. A listener enters into the world the narrator constructs and helps in the telling; thus, narratives are jointly accomplished, according to shared knowledge and interaction rules, and the discourse about projects and actions becomes a joint action by itself.

Storytelling Is a Means to Define Ourselves

We can discover more about ourselves with the support of a sensitive listener than we can on our own. Because people grow up giving and getting each others' stories, we also know the satisfaction that can come from transforming the chaos of experience into a coherent narrative in the course of explaining that experience to someone else. The meanings with which we format the world around us fundamentally define our relationship with it. Meanings are constructed and attributed, and they are inherently subjective. In a psychodynamic view, narrative explanations are part of a network of representations of the self and the world, which provide a causal map, which guides action and enables social relationships to run smoothly. We need to know who we are and where we come from, if we are to relate effectively to others (Holmes 1998). The narrative is a manifestation of an inner representation of self–other relationships, and in psychodynamics these representations derive from early parent–child interaction. Attachment research has distinguished between several narrative styles: secure-autonomous, insecure-dismissive, insecure-preoccupied, and insecure-unresolved (Main, 1995; see also Chapter 11, this volume). Each reflects a particular pattern of talking about oneself and others.

Narratives Are the Means of Making Actions to Others Intelligible

We render our actions intelligible to others through stories because actions have a basically historical character. It is because we live and understand

our own lives in terms of the narratives that we also understand the actions of others through narratives. A *story* is a symbolized account of actions of human beings that has a temporal dimension. The story has a beginning, a middle, and an ending. The story is held together by recognizable patterns of events called *plots*. Central to the plot structure are human predicaments and attempted resolutions (Sarbin, 1986).

Narratives in a Therapeutic Context

The starting point of most clinical encounters is the patient's narrative—the life story sufferers describe, which encapsulates their difficulties, their view of themselves, and their story (Holmes, 1998). Putting stressful experiences into words not only alleviates emotional distress but also exerts positive effects on physiologic measures of arousal (Pennebaker & Seagal, 1999). Persons who talk or write about traumatic experiences are in better health and use medical services less often (Pennebaker, 1997). Nontalking has negative effects on health. People who reported not talking about massive life stressors were more prone to a variety of health problems compared with those who had talked about comparable events (Pennebaker, 1988).

Narratives have a special meaning in the context of change. Ideally, they support a continually changing life, are productive and generative, and enabling and releasing. Mature stories are accepting of uncertainty and integrate it as uncertainty, suggesting a continuing journey rather than confinement and conformity. A good therapeutic narrative interview encompasses all of the relevant facts, makes sense of the experience, is nonstigmatizing, permits the maximum allowable hope, and is credible to both the clinician and the patient. A desired clinical outcome of an act of narrative thinking (or discourse) often is a new story. In postmodern (constructivist) terms, the deconstruction of an operating dominant plot and the reconstruction of a new plot take place through a conversational partnership between client and therapist:

The new plot emerges out of the deconstruction of the dominant plot without concerted effort by the client to consciously design it. . . . The new plot needs to integrate the contents of the old story with the newly available contents. The new contents require a plot that recognizes the agency of one's self (through externalization of the problem). The new plot also opens up a further review of the previously assigned meanings to past life events. (Polkinghorne, 2004, p. 60)

If a clinician can empathically put him- or herself in the patient's predicament, then it will be relatively easy to ask the most productive questions and to provide the most helpful responses. The patient and the interviewer then become fellow travelers in a journey through the patient's narrative. The history of the present suicidal situation should be a "good" story. That is,

it should encompass all of the relevant facts, make sense of the experience, be nonstigmatizing, permit the maximum allowable hope, and be credible to both the clinician and the patient.

Luborsky, Barber, and Diguier (1992) investigated the meaning of narratives told during psychotherapy sessions. From the detailed analysis of the narratives, the authors identified the following characteristics: (a) narratives are common in psychotherapy sessions; (b) narratives are of moderate length; (c) narratives are about recent events; (d) intimate relationships are favored; (e) wishes, responses from others, and responses of self are frequent within narratives. The most frequent wishes were “to be close and accepted,” “to be loved and understood,” “to assert self and to be independent.” The authors concluded that curative factors in psychotherapy are intimately related to the content of relationship narratives. The therapist’s ability to formulate and accurately interpret the relationship themes that are apparent in narratives is associated with outcome, retention, and the development of the therapeutic alliance over the course of treatment (Crits-Christoph, 1998). Comparing two treatment modalities, Crits-Christoph (1998) found that the therapeutic alliance was positively correlated with the number of patient words per relationship episode. The fact that the nature of the treatment modality matters was interpreted as an opportunity for therapists to facilitate the development of more narratives, and more complete narratives in psychotherapy.

SUICIDE NARRATIVES

Suicide is not merely a matter of immediately present circumstances. It also does not have a simple cause. It usually is the culmination of life events, and it has a developmental history. Leenaars (1988), from the study of suicide notes, concluded that although suicide often appears as a solution to the present interpersonal situation, it is strongly related to the individual’s history. Narratives of suicidal individuals usually are about unbearable mental pain (see Chapter 7, this volume). We (Michel & Valach, 1997) proposed a model of understanding suicidal behavior based on an action theoretical approach (see Chapter 8, this volume). Central to action theory is the notion that actions are understood as being carried out by agents, that is, by persons who are able to shape their environment and behaviors. They do this by setting goals, making plans, monitoring their own behavior, thoughts, and emotions. The concept of the agency implies that, at least partly, people have conscious access to their reasons why they act in a certain way. The action conceptualization also implies that the way people make sense of the actions of others and the way people communicate their own actions is through narratives.

Actions are explained on the background of the person's short-term and long-term (life) projects, which involve the person's environment. Suicide as a goal may emerge in critical moments in life when higher order life career goals are seriously threatened thus giving suicide a biographical dimension. Suicide in this context appears as a possible solution to a subjectively unbearable situation. In addition, it may emerge repeatedly throughout life as a possible goal ("to end a miserable life story") in times when major identity goals in the patient's perception are seriously threatened, particularly when a person's self-evaluation is negative ("I am a failure, I am useless").

A narrative approach requires absolute openness and acceptance vis-à-vis the patients, recognizing them as the agents of their own actions. Patients, on the other hand, have the narrative competence to describe and explain the subjective logic behind an act of deliberate self-harm. The shared experience (within which narrator and listener learn together about a life of pain and failure) is instrumental in reestablishing the teller's broken sense of self. The interviewer does not compete as an expert who knows more about the patient than the patient. Instead, the clinician can function as an interested facilitator of an injured person's life story. From such an orientation it is possible for the therapist and the patient to review the past together to learn how the patient's life and the perspectives for the future have become unendurable. Empathic understanding allows the therapist, along with the patient, to grasp how suicide came to be seen as the only available solution. Only then can a therapeutic process begin. The end point in the suicidal person's narrative is either suicide or life. When the story is told and retold to a sensitive listener the end point may change from death orientation to life orientation. Thus, in the case of the suicide attempter seen after admission, in a therapeutic interview, the narrative has the prospect of an alternative solution.

In training courses, mental health professionals sometimes object by pejoratively describing suicidal patients as defensive, resisting, and even hostile. The action theoretical view starts with a positive assumption. If interviewers can convey their genuine interest in and openness toward the patient's story, the patient's goal will usually be to make it a good story—as long as the interviewer allows the patient to pursue this goal. In our clinical experience, it is rare that after attempted suicide, patients refuse the invitation to tell their story. Beyond individual goals, both parties in the course of a therapeutic interview will usually work out common and newly shared goals to be pursued in further sessions.

The narrative interview with the patient who is seen after a suicide attempt typically starts with the clinician's opening intervention, which may be, "First, I would like you to tell me in your own words how it came about that you harmed yourself," or "I would like you to tell me the story of what led to the suicidal crisis. Just let me listen to you."

NARRATIVE OF MR. T.

Duration of the interview was 35 min 20 s.

Mr. T. ("Pat"), a 62-year-old man, was admitted as an emergency patient after he had severed his left hand from his arm with an axe in a serious attempt to kill himself. He was found after several hours and brought by helicopter to the university hospital, where his hand was reattached to his arm. He was interviewed by a psychiatrist 6 days later.

The interviewer opened the interview with the typical question aimed at encouraging the patients to start with their narrative.

Psychiatrist: Is it difficult to talk again about what happened?

Pat: No, not really. Maybe you'll have to help me a little bit when I don't immediately know how to answer your questions.

Psychiatrist: I suggest that you decide yourself where to start and that I'll help you in case you get stuck. It is important that first you tell me your story.

Pat: Yes.

Psychiatrist: So, could you tell me how you got to the point that you wanted to put an end to your life?

Pat: How I got to this point . . . Well . . . Maybe I have to tell you first that I live in a very remote place. There I live in a small house, which I have rented since 2 years. At that time I was still working. I had rented the house together with a friend and his wife, and my girlfriend. They came there to relax over the weekends. During the week I was alone. As long as I worked everything was perfect. All day long I was at the post office, where I worked at the service window. In the evenings I went home. There, there was isolation. I usually drank one or two beers and then went to bed. Weeks went past rather quick. Then came retirement. Actually, I had been looking forward to this moment. I love to go for long walks. And I love to ski. I said to myself that now I can go skiing whenever I want. At the beginning this went rather well. But with time, I became lonely. Normally, I am not a very sociable person. Normally, I don't go into crowds. During the week I could go for supper to my mother. She is 88. She always asked me to come for supper. When she was away on holidays I cooked for myself.

But as time passed I became more and more isolated (here, the patient changes position, seems more tense now). In early summer I found that it got worse and worse. I began to forget things. In discussions with friends I had problems

following the conversation. I started to ask myself questions. I have a young girlfriend. And I had become impotent. Of course, this led to additional worries. I started to think about my life. I simply had to say to myself that if now my friends and my girlfriend left me, then I had nothing left. They all thought that I was somebody who had saved some money. But this is not true. I have nothing besides my pension. Then I developed problems with sleep. Last Monday I had an appointment with a physician. And last Monday I simply said to myself, "No." I was afraid that now everything would come out into the open. I was afraid that people would say that I had always relied on the support of my friends and my girlfriend, and that in fact I had nothing of my own. I would then be called a scoundrel. This really frightened me. So I fetched a knife and cut my blood vessels in the wrist. But I realized this wouldn't work. So I got an axe out and chopped my hand off. I simply wanted to go. So I was lying there for several hours. I was drowsy when the phone rang. I said to myself that I won't answer. After the fourth ring I still picked up the receiver. It was my girlfriend who then called the ambulance. They came and got me into hospital.

These are the first 5 minutes of the interview. Typically, the patient tells the story without interruption, a story that started 2 years ago and ended with the suicide attempt. This first narrative contains crucial information:

1. retirement as a crucial life event where things started to change,
2. the problem of isolation,
3. the development of typical signs of depression, and
4. a serious suicide attempt with a high level of determination.

Themes that so far appear relevant for understanding Mr. T.'s psychodynamics:

1. the fear of being left or rejected by others; and
2. the fear of being discovered as an imposter, as someone who is insufficient and even defective.

Next, the interviewer concentrated on clarifying the short-term aspects that led to the action.

Psychiatrist: This is a heavy story. Let me ask a few questions so that I can better understand all this.

Pat: Okay.

Psychiatrist: So you didn't go to the doctor. This appointment would have been shortly before?

Pat: Yes, I had an appointment in the morning.

Psychiatrist: And you didn't go?

Pat: I was much too afraid. It would have been the second time that I saw the doctor. The first time it was just to check the blood. Because he was away on holidays the first time, there was another physician. Later, I just became frightened. I was afraid that he would now find out something. It is also the memory problem that worries me. This examination might have brought up something awful. I thought that if I went there, something would blow up.

Psychiatrist: Let me ask a bit more specifically. What do you think could have blown up?

Pat: That I had a mental illness or Alzheimer's disease. In our family we have such a case. I was simply frightened that something like this might be discovered. Then I . . . My girlfriend goes to the same doctor. I know there is the law of confidentiality, but still . . . I worried that something would come out into the open. I was afraid that this would trigger something awful.

Psychiatrist: Did you ever talk with your girlfriend about these health and psychological problems?

Pat: No, I kept them to myself. Before, I didn't really have any problems. All this started in summer. I had felt confident. But then all these problems came. In my family they thought that I was an old postman who had saved some money. People always did everything for me. I profited, but not on purpose. I am simply a bit helpless sometimes. But that day everything became clear to me. That morning I simply panicked. I can't think of any other way to put it.

The patient then continued on to explain that the plan to put an end to his life had come to his mind a few days before, that he had thought, "Off you go and away." But still, he said, the morning of the day he had the appointment with his doctor, the decision to finish it all was spontaneous; otherwise he would have bought a gun beforehand.

Pat: This act of desperation came Monday morning. I didn't see any way out.

Psychiatrist: After you had cut yourself—didn't it hurt?

Pat: There was some pain. But not much.

Psychiatrist: Then it was bleeding . . .

Pat: It wasn't bleeding enough. So I got the axe. I thought that then the blood would come faster.

Psychiatrist: You wanted to do it radically.

Pat: I got into a panic. I didn't think any more. I simply thought "off and away."

He then said that he was lying there for several hours. That he simply waited until death would come, that he didn't feel pain.

The interviewer then told him that he was interested to hear more about his life. The patient had left high school early and had taken a job with the post office. He became the head of a small local postal bureau but felt that he could barely cope with this job. Later, the office was closed, and he was transferred to another post office, where he was given a position at the service window. He was married and divorced twice, and he had two daughters. Both of his wives left him. He said that both divorces had been very bad experiences for him. When the second wife threatened to leave him, he drove around aimlessly, determined to kill himself in a car crash. The police stopped him and brought him back. He had now lived for the past 10 years with his present girlfriend and her daughter.

Typical for a narrative interview, Mr. T. did not explain his suicide attempt with a single cause but with a story, which explains the short-term development preceding the attempt, linking it with the relevant parts of his life history. Thus, the narrative contains immediate action-related aspects as well as life projects and aspects of life career. Furthermore, Mr. T. has a good narrative competence, although at the beginning of the interview he needed some encouragement to describe and explain with his own words how he came to the point of harming himself, something we often see with depressed patients who lack the confidence in telling their story.

From closely studying different approaches and interviewing styles, we found that it is absolutely essential that right from the start of the clinical interview the interviewers aim at facilitating the patients in telling their own stories. In the clinical study mentioned earlier (Michel, Dey, Stadler, & Valach, 2004), based on interviews with suicide attempters, we found that patients' ratings of the quality of the therapeutic relationship in the Penn Helping Alliance Questionnaire were significantly higher when the interview opening contained either of the words *tell* or *story*. Therapist interventions should thus convey an active interest and respect, encouraging the patient in developing the narratives. In turn, the clinician provides feedback related to relevant biographical issues, acknowledges emotions and the patients' identity goals, and helps patients to feel comfortable and relaxed. Patients often ask, "How far back do you want me to go?" or "Where do you want me to start?" They usually start with a life project relevant to the suicidal action in question (in Mr. T.'s case, the

retirement and increasing isolation). The interviewer should not interrupt the self-narrative, except to ask clarifying questions. Typically, Mr. T. was well able to deliver his narrative within about half an hour, in the second half of time helped by some prompting questions. Most of our narrative interviews after attempted suicide have a duration of 30 to 40 min, which seems to be a natural length of time of a narrative, also described by others (Bruner, 1987).

Interviewing suicidal patients with a narrative approach allows clinicians to join the patients in their inner experience of suffering. The typical mental state patients describe in their narratives, immediately before initiating an act of deliberate self-harm, is characterized by an acute state of anxious emotional perturbation, which the individual experiences as unbearable. This is consistent with Shneidman's (1993) concept of unbearable mental pain (*psychache*) and of the thought that the cessation of consciousness is the solution for this unbearable condition. In the present case, Mr. T. said he could not live with these thoughts any longer; he simply wanted "to go." Earlier in his life, at a moment of threatened separation and feelings of inadequacy, suicide had emerged as a possible goal or an escape from this state of mind. According to Baumeister's (1990) model of suicide as an escape from self, negative experiences and setbacks in the biography of suicidal patients tend to result in unfavorable attributions about the self, self-blame, and low self-esteem, and, finally, in an acute cognitive deconstruction. Similarly, Maris (1981) contended that self-destructive behavior usually is a means of escape from a long accumulation of painful life experiences. Suicide as a goal may repeatedly appear in critical life situations in the sense of a "suicidal career."

Mr. T. described the suicidal action as a sudden impulse, which he was unable to control. We were struck by similar description, given by many of our patients, of a particular state of mind, in which the suicidal action took place as "automatic, robot-like, trance-like" (Hendin, Maltzberger, & Szanto, 2008) and patients reported not feeling pain or anxiety. Such experiences are typical of dissociative states (Orbach, 1994). *Dissociation* has been defined as a lack of the normal integration of thoughts, feelings, and experiences into the stream of consciousness and memory (Bernstein & Putnam, 1986; Nemiah, 1980). Dissociative reactions are characterized by a disruption of an individual's sense of identity (Maltzberger, 1993). In the frame of a homeostatic model of self-conservation, dissociation is seen as a defense against pain, distress, or humiliation, and against the collapse of the self (Orbach, 2001). Many of our patients reported having felt humiliated by important others prior to attempting suicide, which resulted in a feeling of worthlessness and a loss of self-respect. Others reported having felt emotionally abused, treated like an object, and devalued as a human being. Patients often reported that at the moment of the suicidal action (e.g., when cutting) they did not feel pain. Several reports

have described feeling like an automaton, dominated by feelings of numbness immediately prior to self-injury (Baumeister, 1990; Shneidman, 1980), as well as analgesia (Orbach, 1994).

CONCLUSION

When two people meet in a therapeutic context, they need a common ground to establish some kind of meaningful interaction. In this chapter, we have argued that suicidal actions become intelligible only through a person's narrative. When patients are actively encouraged to tell the story behind a suicide attempt, and when the interviewer is open to listen, patients are well able to tell their story. They want to interpret what happened themselves and create a picture of how they want the health professional to understand their action. The clinician's interventions should be nonjudgmental, complementary to the goals of the patient, and may include clarifying questions. Interpretations that are not patient centered may be seen as an uncooperative gesture and may inhibit the motivation of the patient to engage in a meaningful therapeutic relationship. By joining the patient in the understanding of the suicidal act in a biographical context, the therapist has the unique experience of gaining an insider's view of the patient's suicidality.

A narrative-based approach is no contradiction to evidence-based medical practice (Greenhalgh & Hurwitz, 1999). The patient's narrative is the basis of a therapeutic alliance. It is a subjective account that reflects the patient's inner experience. Without the patient's story, therapy focusing on the patient's suicidality is constrained, if not impossible. On the other hand, there should be no doubt that mental health disorders must be properly identified, but this can be done later in the assessment interview. On the basis of a joint understanding of the patient's suicidality, therapeutic interventions can become a matter of shared decision making. This encompasses seeing patients as persons who would normally be competent in pursuing their own goals and who want to be taken seriously and to be understood (e.g., "I want to be seen as a competent person, I want to be taken seriously, I want to be understood"). Only if we are prepared to listen, and if we can join patients in their individual narratives of the often extreme experience of pain, can we become influential in changing the course of actions and in reestablishing life-oriented goals. The understanding of a person as someone who is normally pursuing his or her individual identity or life-career goals, and who, in situations that fall short of expectations, may come to consider suicide as a short-term goal, enables us to develop interventions in which the other person is seen in the same way as we see ourselves—as responsible and involved in goal-directed and ultimately life-affirming actions.

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