Therapist Sensitivity Towards Emotional Life-career Issues and the Working Alliance with Suicide Attempters

Konrad Michel, Pascal Dey, Kathrin Stadler, and Ladislav Valach

This study investigated the usefulness of an action theoretical model of suicide in interviewing suicide attempters. Eighteen interviews were video-recorded and transcribed. The patients' narratives were reconstructed and life-career issues relevant for the patient's suicidality formulated. Skin conductance response was used to determine narrative content associated with actualized emotions. Scores of the patients' ratings of helping alliance experienced in the interview were positively associated with the therapists' sensitivity towards emotionally relevant life-career issues. Furthermore, relationship satisfaction was related to a narrative interviewing style. We conclude that working alliance in clinical interviews with suicide attempters can be improved when the interviewer uses a patient-oriented approach aimed at understanding the patient's suicidality in the context of personal life-career, or identity issues.

Keywords attempted suicide, working alliance, narrative approach, action theory

Attempted suicide is the main risk factor for suicide (Bille-Brahe, Kerkhof, De Leo et al., 1997; Runeson, 2002). The risk remains high for more than 20 years after the attempt (Jenkins, Hale, Papanastassilou et al., 2002) and increases with each subsequent suicide attempt (Goldstein, Black, Nasrallah et al., 1991). In spite of identified risk factors for suicidal behavior (Harris & Barraclough, 1997, Hawton, Fagg & Platt, 1993) there is little evidence that aftercare programs for suicide attempters reduce the risk (Hawton, Arensman, Townsend et al., 1998). Suicide attempters often discharge themselves or finish treatment prematurely (Crawford & Wessely, 1998), and non-attendance at follow-up interviews is high (Möller, 1990). Compliance was found to be somewhat better when the outpatient appointment offered to the patient was with the same person who conducted the initial assessment interview, but even then, non-compliance for the first outpatient interview was 50% or more (Kurz, Möller, Bürk et al., 1988, O’Brien, Holton, Hurren et al., 1987).

Poor treatment compliance may be related to difficulties in establishing a working relationship with suicidal persons. The quality of the working relationship between patient and therapist is a common factor for outcome, not only in psychotherapy.
Suicide appears as a possible solution to or escape from a subjectively unbearable life situation and may repeatedly (and increasingly) throughout life emerge as a possible goal ("to end a bad story") when major life-career or identity goals are seriously threatened. The term life-career conceptualizes long term personal, joint and socially embedded developmental processes of individuals, such as identity, relationship or occupational career (Young, Valach, Ball et al., 2001). In a similar way, Maris (1981) used the term suicidal career to describe the individual long term development of a person’s suicidality. Furthermore, human agency also implies that the person as the agent can give a narrative account of an event (White, 1991). Narratives about events and agency may extend beyond the conscious awareness of the protagonist (Holmes, 1998) and are therefore likely to include actualized emotions related to life-career issues. According to an action theoretical model these are often emotions related to failed identity goals.

We hypothesized that if persons who had attempted suicide were encouraged to give a narrative account of the suicide attempt in a biographical context, these patients would report higher satisfaction with the therapeutic relationship. The aim of our study therefore was to determine if in a first assessment interview the patient’s evaluation of helping alliance was associated with the therapist’s skills to reach a patient-oriented understanding of the patient’s suicidality in the context of life-career issues.

**METHOD**

**Procedure**

Suicide attempters admitted to the emergency unit of the Bern University Hospital were routinely approached by a member of the research team and asked if they would participate in a research
Interviews were completed with full EDA recording. They represent a sample of a total of 40 interviews with suicide attempters (25 women, 15 men) consecutively admitted to the emergency ward of the Bern University Hospital, all of whom were interviewed with the procedure described above. EDA recording was limited to 18 interviews due to the technical and organizational limitations in recording the patients’ skin conductance, and does not imply any systematic bias. This sample (11 women, 7 men, mean age = 41.7 years, range 17 to 80) was comparable to the total of 162 suicide attempters admitted to the university hospital in 1998, in mean age (t = .93, df = 17, p = .37), sex distribution (chi^2 = 45, df = 1, p = .61), and methods used (overdosing vs. other methods, chi^2 = 30, df = 1, p = .64). Eight patients had attempted suicide in the past. Thirteen patients overdosed and 5 used other methods (shooting, cutting, jumping). On the average, the interviews were carried out 8.3 days after the event (range between the same day and 23 days). On the Beck Depression Inventory, 4 patients were classified as not depressed, 2 patients as mildly, 5 as medium and 4 as severely depressed at the time of the interview. Three questionnaires were incomplete.

**Interviewers**

Interviews were carried out by eight senior psychiatrists and trainees, two of the interviewers (K.M. and L.V.) being familiar with an action theoretical model of suicidal behavior. The interviewers were told to reach, in a short interview of ca. 30 minutes duration, an understanding of how the patient came to the point of harming himself or herself. No further instructions were given, thus interviewers were allowed to use their personal interviewing styles.

In order to categorize the interviewer’s approach toward the patient, interviews were divided into two groups according to the opening of the interview. If an interviewer used sentences such as “I would like you to tell me in your own words”, or “I would like to hear the story that is behind your suicide attempt” the approach was...
for the purpose of this study categorized as narrative, while other interview openings starting with (closed) questions, that is regarding the circumstances of the suicide attempt or the method used (“What exactly did you do?”) were labelled as “non-narrative.”

Helping Alliance

The Penn Helping Alliance Questionnaire (HAq) is an 11-item self-rating questionnaire on the quality of the patient-therapist relationship. We used the German version by Bassler, Potratz, & Krauthauser (1995). These authors isolated two subscales: (1) satisfaction with the relationship (6 items), and (2) satisfaction with the outcome (5 items). The Penn Helping Alliance Rating Scale has been shown to have a good predictive validity for psychotherapy outcome (Fenton, Cecero, Nich, et al., 2001).

Patients’ Narratives

A concept of hierarchical organisation of goals (in terms of actions, projects and life-career aspects; Valach, Michel, Young et al., 2002) was used to reconstruct the patients’ narratives and to identify the main life-career issues expressed by the patient in connection with the suicide attempt. The interviews were fully transcribed and the patients’ narratives reconstructed verbatim in a hierarchical order (content related to (1) suicide action, (2) relevant projects, (3) life-career issues). For instance, a statement such as “I couldn’t live with these thoughts any longer – I wanted to escape from them” was considered to be related to the suicide action. “My boyfriend said it was all over” was related to a (relationship-)project, while “I have great problems in coping with separation and loss” was considered a life-career issue. From the reconstructed narratives the main life-career issues that would most likely be addressed if the patient was to be taken into psychotherapy were formulated independently by each member of the research team. Discrepancies in the formulation were discussed and a consensus reached, allowing a maximum of three issues per patient.

In the transcribed interviews, all content related to relevant life-career issues as defined above was identified and marked throughout the text.

Electrodermal Activity

Patients’ skin conductance was used as an additional physiological measure to help identify issues in the narratives that had a special emotional meaning for the patient. Skin conductance response (SCR) has been shown to be a useful physiological parameter related to emotionally meaningful topics (Griffin, Resick & Mechanic, 1997). It has been reported that SCR is suitable for monitoring emotionally charging states in natural conditions of an interview (Boucsein, 1992; Kaeferman, & Altdorfer, 1989). Video and SCR had simultaneous true time recordings (accuracy 1/10 second) which made it possible to synchronize the transcribed interviews with the SCR curve. Physiological arousal was defined by the amplitude of the skin conductance response calculated as the difference between the peak and the base value higher than $z = 1$. SCR artefacts due to body movements, coughing, yawning and so on were omitted.

Electrodermal activity was recorded continuously during the interviews with a MedNatic PhysioModul-system, using a constant 500 mV source. A pair of 1 cm$^2$ Ag/AgCl electrodes was attached to the hypothenar eminence of the nondominant hand. Signacreme electrode cream was used as electrode medium.

Skin conductance response (SCR) was measured in microsiemens, with a time constant of 10 sec. The PhysioModul-system allows real-time waveform display of the data. SCR amplitudes were computed
off-line from onset to peak using commercial software (after Thom, 1988). All SCR peaks identified as artefacts from video were excluded.

Life-career issues in the patients’ narratives identified independently as described above were then related to the SCR curve. Those occurring with SCR peaks $z > 1$ during and up to five seconds after the relevant episode were categorized as emotionally relevant. These sequences were defined as “crucial interview moments” and were used for analysis of the interviewer’s response.

Therapist Sensitivity Toward Life-career Issues

For each “crucial interview moment” (as defined above) the consecutive therapist’s intervention was evaluated. Therapist sensitivity toward central life-career issues was operationalized as an intervention expressing acknowledgement of the subjective relevance of the issue ($0 =$ therapist does not support or recognize the importance of the issue, i.e. is either not referring to the issue or addressing it in a devaluing or critical way.; $1 =$ the therapist recognizes the importance of the issue, i.e. is either addressing it or referring to the actualized emotion). The rating was first done independently by each research member, followed by a conference rating.

Statistics

SCR values were $z$-transformed (Boucsein, 1992) and the threshold for emotionally significant changes was set at $z = 1$. The height of SCR amplitudes has been found to be positively related to the height of emotional arousal (Greenwald, Cook & Lang, 1989; Lang, Bradley & Cuthbert, 1998; Vehrs & Zschuppe, 1982).

For the examination of the relationship between the sensitivity of the therapist intervention and the patient-therapist relationship Pearson’s product moment correlation was calculated. To control for other variables (depression, age, gender, the number of emotionally significant episodes) partial correlations were calculated. Nonparametric tests were used to determine statistical significance of the difference in HAq scores between narrative and non-narrative interview approaches. All calculations were performed using the PC version of the SPSS 10.0 software.

RESULTS

For the 18 patients a total of 45 life-career issues relevant for the suicide action were formulated from the transcripts. The most frequent themes dealt with (1) problems with self-esteem, (2) difficulties in coping with separation and loss, (3) experiences of rejection, and (4) feeling restrained and dependent in a relationship.

The patients’ utterances were categorized as follows: Patients’ turns during interview ($n = 1,388$), short turns not evaluated for their emotional content (“Yes”, “No, never”; $n = 459$), turns containing relevant life-career issues ($n = 294$), turns containing relevant issues and physiological arousal ($n = 163$). Nineteen of the latter were not used for the evaluation of the interviewer’s response, as they occurred within a longer narrative passage where it is appropriate not to interrupt, which left altogether 144 interview sequences to be used further for evaluation of the interviewer’s sensitivity towards relevant life-career issues.

Therapist Sensitivity Toward Life-career Issues

In each interview between 3 and 14 interviewer interventions following the relevant life-career issues associated with actualized emotions were identified and rated, thus providing numbers of appropriate and not appropriate responses.
Therapist sensitivity was then defined as the number of helpful or appropriate interventions (score = 1) divided by the total number of interventions rated in each interview. The proportions of appropriate interventions in each interview varied between 40% and 100%, with a normal distribution. The interjudge reliability was satisfactory (Cohen’s Kappa = .64).

**Helping Alliance**

The HAq scores yielded normally distributed values (M = 15.1, SD = 10.3; relationship subscale M = 10.4, SD = 5.9), but not in the outcome subscale (M = 4.6, SD = 6.3).

**Correlation Between Helping Alliance and Therapist Sensitivity**

The HAq scale and HAq subscales were related to therapist sensitivity as defined above. A significant correlation was found between therapist sensitivity and the HAq subscale ‘satisfaction with the relationship’, but not with the total score or with the subscale ‘satisfaction with the outcome’ (Table 1). Product-moment correlation revealed a negative association between HAq and the patients’ BDI score. Partial correlations controlled for BDI were significant for HAq and both subscales (Table 2).

Partial correlations remained significant for the relationship subscale when controlled for age (p = .02), and gender (p = .03). When controlled for the number of emotionally loaded episodes per interview the correlation between therapist sensitivity and relationship subscale was statistically not significant.

Regarding individual items of the HAq (Table 3), the correlation with the therapists’ sensitivity towards relevant life-career issues was significant for the items (1) ‘I believe that my therapist is helping me’, (2) ‘I believe that the interview is

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**TABLE 1.** Product-moment Correlation Between Patient Evaluation of Helping Alliance and Sensitivity of Therapist Interventions Towards Emotional Life-career Issues, N = 18

<table>
<thead>
<tr>
<th>HAq Scales</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAq, total(^1)</td>
<td>.36</td>
<td>.069</td>
</tr>
<tr>
<td>a. Subscale relationship satisfaction(^2)</td>
<td>.45</td>
<td>.032*</td>
</tr>
<tr>
<td>b. Subscale outcome satisfaction(^2)</td>
<td>.18</td>
<td>.238</td>
</tr>
</tbody>
</table>

\(^1\)HAq = Helping Alliance Questionnaire (Alexander and Luborsky, 1986). \(^2\)Bassler, Potratz, & Krauthauser (1995). *p < .05.

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**TABLE 2.** Partial Correlations Between Patient Evaluation of Helping Alliance and Sensitivity of Therapist Interventions Towards Emotional Life-career Issues, Controlled for Depression (BDI), N = 17

<table>
<thead>
<tr>
<th>HAq Scales</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>HAq, total</td>
<td>.54</td>
<td>.029*</td>
</tr>
<tr>
<td>a. Subscale relationship satisfaction</td>
<td>.50</td>
<td>.042*</td>
</tr>
<tr>
<td>b. Subscale outcome satisfaction</td>
<td>.50</td>
<td>.043*</td>
</tr>
</tbody>
</table>

*p < .05.
helping me’, (7) ‘I feel that the therapist understands me’, and (9) ‘I feel I am working together with the therapist in a joint effort.’

helping alliance in the HAq was higher when an interviewer used a narrative opening of the interview as described above (n = 10; non-narrative openings n = 7, Mann-Whitney U test: p < .01, two-tailed). The same was true for the subscale “relationship satisfaction” (Mann-Whitney U test: p = .03, two-tailed).

**DISCUSSION**

The objective of this study was to determine if in a first psychiatric interview with patients who had recently attempted suicide, the patient’s evaluation of the helping alliance was related to the interviewer’s skills to understand the patient’s suicidality in the context of relevant life-career issues. Improving early alliance with suicide attempters is of utmost interest for suicide prevention because of the notoriously poor compliance of these patients and the disappointing results of aftercare programs (Hawton, Arensman, Townsend et al., 1998). In particular, the patient’s early evaluation of helping alliance is a major determinant of compliance and outcome in psychotherapy (Martin, Garske & Davis, 2000). It should be noted that patients’ ratings of helping alliance have been found to be better predictors of therapy outcome than therapists’ ratings (Horvath and Samps; Symonds, 1991).

The results suggest that working alliance can be improved when an interviewer with his or her interventions acknowledges the meaning of emotionally relevant life-career issues for the understanding of the patient’s suicidality. This is consistent with psychotherapy process studies which found that therapeutic alliance is related to the quality of therapist interventions (Crits-Christoph, Barber & Kurcias, 1988; Horvath & Luborsky,

**TABLE 3. Product-moment Correlations Between Sensitivity of Therapist Interventions Towards Emotional Life-career Issues and Helping Alliance Items (Wording of Helping Alliance Items Adjusted to Single Interview Setting, Changes in italics, e.g. Interviewer Instead of Therapist), N = 18**

<table>
<thead>
<tr>
<th>Helping Alliance Items</th>
<th>r</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I believe that my <strong>interviewer</strong> is helping me</td>
<td>.41</td>
<td>.045*</td>
</tr>
<tr>
<td>2. I believe that the <strong>interview</strong> is helping me</td>
<td>.47</td>
<td>.025*</td>
</tr>
<tr>
<td>3. I have obtained some new understanding</td>
<td>.11</td>
<td>.339</td>
</tr>
<tr>
<td>4. I feel better <strong>after the interview</strong></td>
<td>.01</td>
<td>.491</td>
</tr>
<tr>
<td>5. I can already see that I will eventually work out the problems (I came to treatment for)</td>
<td>.12</td>
<td>.319</td>
</tr>
<tr>
<td>6. I feel I can depend upon the <strong>interviewer</strong></td>
<td>.39</td>
<td>.062</td>
</tr>
<tr>
<td>7. I feel that the <strong>interviewer</strong> understands me</td>
<td>.59</td>
<td>.007**</td>
</tr>
<tr>
<td>8. I feel that the <strong>interviewer</strong> wants me to achieve my goals</td>
<td>.37</td>
<td>.064</td>
</tr>
<tr>
<td>9. I feel I am working together with the <strong>interviewer</strong> in a joint effort</td>
<td>.44</td>
<td>.033*</td>
</tr>
<tr>
<td>10. I believe we have similar ideas about the nature of my problems</td>
<td>.12</td>
<td>.329</td>
</tr>
<tr>
<td>11. I feel now that I can understand myself and deal with myself on my own</td>
<td>-.03</td>
<td>.454</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01.*
In particular, therapeutic alliance was shown to be associated with the accuracy of therapist interventions in relation to central issues in a person’s life (Crits-Christoph, Barber & Kurcias, 1993; Luborsky & Crits-Christoph, 1990). Furthermore, the findings are consistent with an action theoretical model of suicidal behavior as proposed and described earlier (Michel and Vamp; Valach, 1997; Michel, Dey & Valach, 2001). Actions are understood as the result of a hierarchical system of goal-oriented processes in an individual’s life. Inherent in this model is the notion that persons explain and understand actions in the form of narratives. A narrative approach helps the patients in actualizing the embedded emotions, and therapists to understand these emotions within the related life-career issues (Holmes, 1998; Valach, Michel, Young et al., 2002).

The correlations of interviewer sensitivity with single items of the Penn Helping Alliance Questionnaire support the validity of the findings, the strongest correlations being for No. 7 (I feel that the interviewer understands me), No. 2 (I believe that the interview is helping me) and No. 9 (I feel I am working together with the interviewer in a joint effort). The Penn Helping Alliance Questionnaire focuses on a shared experience between patient and therapist. The correlations between therapist sensitivity and quality of helping alliance are more robust when controlled for depression scores. This suggests that depression negatively affects helping alliance, a finding which corresponds with clinical experience.

A therapeutic alliance requires the active participation of the patient at every stage of a clinical interview, particularly so in the initial interview. The association of a narrative opening of the interview with HAq and relationship satisfaction is not surprising. Life-career aspects related to attempted suicide can best be accessed with a narrative approach, and, probably more important, the narrative account has in itself a therapeutic potential, giving the teller of the story the opportunity to give meaning to experiences. The categorization was based on a simple concept: A narrative approach should manifest itself within the first few minutes by the interviewer inviting and encouraging the patient to tell the story with his or her own words.

There are a number of limitations inherent in this study. First, the sample of patients is small. It should be taken into consideration, however, that this is a study dealing with interactive interview processes, which required the use of qualitative research methods. We did not attempt to test the preventive power of our model – this will be the objective of further research using quantitative methodology.

Second, it is undoubtedly difficult for the patients to rate alliance after a short interview of ca. 30 minutes duration, knowing that they would not continue to see the interviewer for therapy. The Penn Helping Alliance Questionnaire was developed for ongoing psychotherapy, although it has been shown that a therapeutic alliance can be formed in a first interview (Morgan, Luborsky, Crits-Christoph et al., 1982). Considering the restricted setting of our clinical interviews, it is still surprising that we found significant correlations. Moreover, the fact that the correlations were significant for the relationship subscale but not for the outcome subscale indicates that the patients’ ratings reflect the special situation of the clinical interview. Consistent with this, the correlations for the single items indicate that the perception of being understood and of trust in the therapist were particularly important for the patients, in contrast to items that would expected to be more relevant in ongoing therapy (e.g. items 3, 4 and 5).
Third, we can not exclude a possible bias in patients answering the Penn Helping Alliance Questionnaire. To avoid this, patients were made to fill in the HAq after the interviewer had left. However, the knowledge that this was a research interview may have influenced the patients’ ratings. It might also have encouraged patients to be more active in the interview in order to help the interviewer in his or her task to understand what made them attempt suicide. Therapist sensitivity was rated from the transcripts, not from video, therefore nonverbal cues did not confound the picture. The HAq scores were not known to the raters of interviewer sensitivity. It is remarkable that some interviewers who on video appeared to be very empathic and understanding were given low HAq ratings by the patients. Not surprisingly, the number of emotionally loaded episodes per interview affected the strength of the association between therapist sensitivity and helping alliance, as well as vice versa. This suggests that an unfocused empathic attitude alone is not sufficient to reach a good relationship satisfaction.

Suicide has to be properly conceptualized before we can prevent it (Maris, 1981). A major aspect of the therapeutic value of a model is its potential in creating a therapeutic alliance with suicidal patients. Our study was designed as a pilot study to apply a novel model of suicide as goal-directed action in clinical interviews. An interviewer who believes in the patients’ ability to explain their actions will be able to develop an empathic and shared understanding of the importance of emotional and painful experiences related to the suicide attempt. The findings suggest that an attitude in which the clinician acknowledges the subjective meaning of life-career issues and thus the importance of the narrative content in understanding the patient’s suicidality strengthens the therapeutic relationship. It must be emphasized that a patient-oriented approach is no contradiction to a diagnostic assessment (Greenhalgh, 1999); on the contrary, interviews that are “patient-led” have been associated with increased rates of cue emission for psychological distress in the General Health Questionnaire (Goldberg, Jenkins, Millar et al., 1993).

In suicide research there is a need for treatment studies that help us clarify the relationship between therapeutic alliance, compliance with aftercare and repetition of suicidal behavior. Regarding an action theoretical model of suicidal behavior, the next step should be to test its usefulness in these terms.

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