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Casebook Suicide and Suicide Prevention

Twelve Suicide Attempts Analyzed by Action Theory

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Abstract

The aim of this book is to give the reader an insight into the suicide process from several perspectives through the narratives of the suicidal people. A writer and systems therapist and two psychologists with journalistic, counseling, and therapeutic experience freely tell the story of suicidal people through these people's conversations with a medical professional. A psychotherapist who is also a researcher provides an understanding of these conversations and the suicide attempt as a process of action. What do the patients tell, what did they experience in their suicide attempts, and what happens in the conversations with doctors and psychiatrists? How can we understand these suicide attempts and develop an effective suicide prevention procedure from this understanding?

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Contents

Introduction

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These interviews originate from a university clinic in Switzerland. They were conducted as part of a project supported by the Swiss National Science Foundation entitled "Suicide as Goal-Directed Action" (No.: 32-49313.96). The patients gave their explicit consent to participate in the project and to anonymized publication of their reports (all names, place, and time data are alienated). They were recruited to participate in a university hospital and were therefore able to talk about their experiences and their crises with a psychiatrist a few days after their suicide attempt. These conversations were documented on film. The scientific evaluation was published in several publications, discussed with many suicide experts from all over the world, and further developed at Aeschi meetings (Aeschi working group, http://www.aeschiconference.unibe.ch/), which resulted from this research. It eventually enabled the development of a suicide prevention program (Gysin-Maillart & Michel, 2013) in which the likelihood of people committing suicide attempt(s) again was reduced by 83% and 80%, respectively (Michel et al., 2017; https://www.assip.ch/). This is a unique achievement in suicide prevention!

In this book, we present the suicidal events of individual patients in a twofold manner. In each case, a suicidal person is introduced with a short story which, while closely following the actual course of action, certainly makes use of "poetic license" in the presentation of details. This story is then followed by an orderly presentation of the narrative of the suicidal event in long-term and medium-term concerns and short-term actions. The patient's suicidal action is then examined in terms of a number of important problems that we consider relevant to suicidal action. We address the problems of action organization,

discuss whether the suicide was consciously prepared or spontaneously undertaken, analyze any problems of action monitoring processes, describe the problems of action energizing, emphasize the role of joint action in suicide, list the individual actions of the patient's interview with a medical professional, and provide information about the sections of the self-confrontation interview.

In the concluding part, we discuss the consequences we drew from these studies and then describe the procedure in suicide prevention after a suicide attempt.

▶ Summary

1. With the question "Is suicide a goal-directed action?", interviews were conducted with patients shortly after their suicide attempt, these were then further monitored and analyzed. Here the narratives are presented once in a story and then examined in an action analysis.
2. The analyses were discussed and refined over several years with an international group of suicide prevention experts from medicine and psychology.
3. A suicide prevention program has been developed.
4. A 2-year suicide prevention intervention study was then conducted with a control group, which yielded excellent results.

Part I

Suicide: Conceptual Considerations

Suicide and Suicide Attempt

1

Following an increase in the 1970s, the suicide rate (in Switzerland) fell again from 1980 onwards. Since 2010, it has stabilised at an average of 11 deaths per 100,000 inhabitants. The suicide rate for men is around three times higher than that for women. In 2015, the suicide rate was 16.6 deaths per 100,000 men and 5.7 deaths per 100,000 women. This compares to an average of 17.9 for men and 4.9 for women in European Union countries in 2015. (Federal Statistical Office). The number of suicide attempts is about 15–20 times higher. The lifetime prevalence of suicide attempts is about 30% higher in women than in men (Peter & Tuch, 2019). However, a suicide attempt should not be taken as a reason for relief (it went smoothly this time), but as a serious warning, because a previous suicide attempt is a factor from which one can predict a suicide with the highest probability.

Something different from the suicide rates are the direct encounters with suicidal patients or the suicide experiences of people from the family or acquaintances. Such extreme experiences are not only deeply moving and destabilising for the suicidal persons themselves, but also for the relatives and friends. We ask ourselves again and again "how come and why", which even science is unable to answer unequivocally. The scientific explanatory models contain many individual psychological, physical, biographical and social aspects and lead only to rough estimates of the possible suicide. The main finding of an extensive analysis of existing empirical studies was that the risk factors studied only weakly and inaccurately predict suicidal ideation and action (Franklin et al., 2017). What we do know, however, is that a previous suicide attempt plays an important role in future suicide or suicide attempt. It is therefore of paramount importance that we give our full attention to individuals following a suicide attempt, whether as lay or professional people (Michel et al., 2002).

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Our examination of the conversations and reports of such persons is also motivated by this insight. It led to the successful prevention programme mentioned above in the Introduction. Here we would like to bring the suicidal persons and their stories closer to the readers and explain our theoretical-scientific considerations using these examples.

▶ **Summary**

1. Despite the temporary decline in suicide rates in Switzerland, suicide remains not only a social problem but also, and above all, a personal one for all concerned.
2. Understanding and explaining suicide, as risk research does from probability correlations, led to only very limited and unconvincing results.
3. It is therefore necessary to adopt a different point of view, namely that of the goal-directed acting person, as conveyed by suicidal patients in conversations, in suicide research.

1.1 What Is Suicide or Suicide Attempt?

There are countless books and scholarly and popular journal articles devoted to this question, and we will not repeat those accounts here. For our understanding of what follows, it is important that we recall the historical trajectory of society's conception of suicide. However, we do not have to go very far into the past to visualize the change from religiously motivated ostracism, criminal prosecution, social taboo to the understanding of suicide as a disease. However, in our years of studying the problem of suicide, we have come to the conclusion that understanding suicide as an action is helpful in suicide prevention (Michel & Valach, 2002). Of course, it is not a rational or optimal action, but suicidal patients are to be supported in their intentionality and responsibility. Only in this way can a self-determined, goal-directed and responsible life then be established after a suicide attempt (Valach et al., 2011).

▶ **Summary**

1. The social view of suicide changed greatly throughout history.
2. Although suicidal persons must be relieved of guilt and ostracism, the view of suicide as a natural occurrence or as a disease is of only limited help, since the person's capacity to act is required in therapeutic suicide prevention.

1.2 Suicide as an Action

What does it mean when suicide and suicide attempt are seen as goal-directed actions? Let us realize that we spend the whole day in actions. Not everything we experience is intentional – we can also slip or trip – but already the effort to regain our balance is an action, even if many movements are unconscious and automatic. The decision: "Now I'm going

to play in a slapstick play and fall in a funny way, but without hurting myself," however, can be made and is acted upon.

An action lasts a few minutes and can be separated from the ongoing stream of behavior by attributing or implying a goal (this is where brushing teeth begins and this is where it ends). Going to the bathroom in the morning, eating breakfast, going to work, school, or traveling, doing school, study, or work assignments constitute actions. Such an action can be described as on a sheet of music paper. At the top is the name for the goal that the action is intended to achieve. Below that, the individual steps are described as to how this goal is achieved (Goal: Eat breakfast. Steps: squeeze oranges, thoughts, how will the weather be today, get dishes out of the kitchen cabinet, take blueberries and yogurt out of the refrigerator, thoughts, must buy yogurt again, wash blueberries, open yogurt container and portion yogurt, take nuts and dried fruit out of the pantry and serve a portion, etc.). On the bottom line or level we can describe the individual movements we make while performing the action steps. For scientific purposes, this could be very detailed and comprehensive (e.g., body turning in °, displacement in cm, voice volume in dB, etc.). It is also necessary because the precision of the execution of certain procedures is recorded here (Kalbermatten & Valach, 2020). In the case of attempted suicide, the doctor will ask "Did you want to die?" (question about a goal), "tell me how you proceeded, step by step" (question about action steps), "how long did it take?", "how many pills did you take?" (question about the elements of action, about the physically defined characteristics of the action). These three levels of action are also associated with the individual processes of action. A goal stears the action, in the action steps the action is controlled (do these steps lead to the desired goal) and in the action elements the automatic regulation of action takes place. We remember, when we slip, we automatically seek to gain balance, we regulate the action, because we want to arrive without incident and injury.

In addition to this organization of action in this depicted action system, a number of other action processes take place, such as monitoring or self-monitoring or action-monitoring by consciousness, emotions and pain sensations, such as energization, and others (Valach et al., 2002a, b, c). Further, it is significant to know that an action consists of observable parts, subjective components, and the commonly shared social meanings (Young et al., 2005, Young et al., 2015). That is, not only the scientist who systematically observes attentively or the suicidal person who talks about the inner experience contribute to the description of the event, but also the fellow citizen who sees the event and can make sense of it.

We analyzed the narratives of the suicidal persons and showed that the persons describe the suicidal event in actions and thereby represent the individual action processes. It would therefore be important that the interlocutors of the suicidal persons engage in this way of looking at things and also make use of this terminology in order to achieve a joint understanding with the patients (Michel & Valach, 2011). In this book, we aim to elaborate the individual actions of the respective suicidal narratives in order to depict the action processes of each suicide attempt.

▶ **Summary**

1. Understanding suicide as an action does not simply mean that there was a suicide goal, but that the whole event must be examined with the detailed concepts of a theory of goal-directed action.
2. Suicidal events have a visible part, consist of internal processes of the suicidal person, and take place in a social environment from whose understanding we all draw our ideas.
3. A suicidal action has a goal, is carried out in a series of action steps, and is accomplished in many unconscious movements and action elements.
4. A suicidal action is directed, controlled and regulated. It is monitored in attention, emotions and pain, and energized.

1.3 Suicide Is an Action in a Project and a Long Term Career

Every action, including a suicidal action, does not come out of nowhere, but is part of a project or a medium-term concern. A project is a medium-term unit of action that usually extends not over minutes like an action, but over days, weeks and months. A project should not be understood as, for example, planned and executed by an architect in a rational context. However, we know that from the experience of action we develop skills with the help of which we organize our medium-term concerns. In the case of suicide, patients told us how they dealt with suicidal ideation for prolonged periods of time, or struggled with problems that eventually led to the suicide attempt. Many suicide attempters also reported that their suicidal action was related to experiences in childhood, school, work, relationships, and that these years-long processes need to be mentioned in order to understand the suicidal action (Valach et al., 2002a, b, c). In this book, we try to describe the medium-term and long-term processes of individual suicidal persons that are superimposed on the suicidal action.

▶ **Summary**

1. A suicidal action takes a few minutes.
2. However, it is part of a "suicide project" that can last several hours, days and weeks.
3. Suicidal actions and projects take place within a longer-term framework or concern, which includes any suicide-related experiences the suicidal person may or may not be aware of. Years or even decades are involved.

1.4 Suicide Is Socially Embedded

The notion of an action, in a project and a career would not be complete without describing the joint actions or group actions. A group action can be represented in the same way as an individual action, except that two levels must be considered: the individual action of the individuals and the group action of a group of people striving for common goals (Valach

et al., 2002a, b, c). When a family sets out to spruce up their apartment or house on a day off in the spring, it is more than a sum of the actions of individuals. Their work wants to be coordinated and the division of labor expedient. Thus, the action of suicide can also be viewed from this perspective. The fact that the suicide action has to be understood as socially embedded, which we proved with an analysis (Valach et al., 2006a), can be illustrated in different ways. First, suicidal individuals reported that their crisis, for example, can be understood in terms of a relationship with another person. Be it the rejecting partner, the parents by whom one did not feel understood, the employer who decided too harshly, other caregivers by whom one was afraid of rejection, etc. By extension, the suicidal action is also often presented as an action step in relationship formation. Finally, one felt called to commit suicide because it was understood as a task of the suicidal person in a joint action or project. "Things will be better without me" or similar (Valach et al., 2007).

► **Summary**

1. Although the final steps of a suicide must necessarily occur as an individual action, patients tell us after a suicide attempt that their contacts with other people must be consulted in order to understand their action.
2. The joint projects in which a suicidal action took place must then be examined as joint actions, giving a different meaning to the individual actions and their parts as joint actions.

1.5 Suicide Can Be Consciously Prepared or Spontaneous

It is very plausible to argue that an action can be prepared or spontaneous. However, it must be borne in mind that even a spontaneous action is directed in its course by a goal and is also directed towards a goal. The external stimulation of an action presents itself as an evocation of a project other than the one in which one is engaged at the time with an action. In the case of suicide, one may be engaged in a life-affirming project (e.g., having a conversation with one's partner), then be exposed to an existentially threatening emotional injury, see a gun or a packet of sleeping pills, which elicits a suicidal project from which a suicidal action subsequently ensues. This action, although spontaneously initiated, is again a goal-directed action (Valach et al., 2006b). In an analysis, we showed that there are also mixed types of suicidal actions, partly prepared, in certain parts spontaneous.

► **Summary**

1. Although all suicidal processes are actions, the shift from a life-oriented to a death-oriented project to bring about a suicidal action can occur in a deliberate and prepared manner (top-down) or in a sudden, externally triggered manner (bottom-up).
2. Even in the case of a "bottom-up" controlled suicide process, however, it is an action, because if an impulse can also be taken over, such a reaction is carried out in an action.

1.6 Suicide Is a "Damaged", Defective Action

May the action planned in advance in a project be well thought out, such an action as described above, initiated in an all overflowing sense of threat and loss by an external cue – namely, the presence of a suicide means, be it a gun or a packet of drugs – is certainly less thought out, if at all. Yet it is a goal-directed action. This leads us to the next argument in our suicide research, that suicide should be seen as a damaged or defective action. Damaged in the sense that certain processes in the suicidal action are incomplete, damaged, or do not occur at all, which can result in death. This is also confirmed in a number of studies that tracked brain functions related to suicidal ideation (Reisch et al., 2010). We have been able to identify a number of faulty action processes that can be found in a suicidal action but not in an optimally proceeding action (distorted action) (Valach et al., 2016). We will elaborate on these issues in our discussion of the individual accounts of suicidal patients. Since we are drawing on the theory of goal-directed action with the view that "suicide is to be seen as a goal-directed action", we can examine whether the processes defined in this theory are optimally or defectively proceeding in a suicide action.

For example, in suicide, self-monitoring or self-monitoring systems such as pain, emotion, thought, or attention fail (Valach & Young, 2018). Thus, memories (Ventrice et al., 2010) and especially emotion memories play a crucial role in suicide. For example, we experience the fear of being abandoned as existentially threatening in adulthood because the memory of the fear of being abandoned in childhood is really a memory of a life-threatening situation. At 3 years old, we do not know about the care providers who would take over our care if we lost our mother.

► **Summary**

1. Suicide is indeed an action, but a damaged action or a flawed action.
2. The problems of suicide action can be found in action organization, action control, action monitoring, action energizing, and many other action processes.

1.7 What Is the Purpose of Seeing Suicide as an Action?

The value of gaining knowledge can be determined by the extent to which the knowledge corresponds to reality. In addition, however, an insight is meaningful if it enables us to survive. Not the survival of individuals at the expense of others, but of individuals and others, and not only in the short term, but also in the long term (Valach & Young, 2015). Thus, we can ask ourselves if this view also allows us to save the lives of individuals, in our case, individuals following a suicide attempt.

► **Summary**

1. It is useful to view suicide as an action, as this view allows for effective suicide prevention.

1.8 Talking to a Patient After a Suicide Attempt

The meeting of people is embodied in a conversation. A person after a suicide attempt will possibly seek a conversation with others. However, we are on our own business and that is fine as long as we do not limit others. In all likelihood, in a conversation with a suicidal person, we will want to assure ourselves that we are innocent of it. Then we will possibly be interested in where the dangers are so that we can avoid them. Finally, we will want to do something for our social and ethical standing and offer the suicidal person our understanding, assistance and help. In many cases, the suicidal person will experience similar things from the professional interlocutors. The family doctor or psychiatrist will look for symptoms of mental illness in order to make a diagnosis, possibly depression, which could be treated with medication. Above all, the doctor will seek to proceed correctly and properly. The doctors in a hospital will also question the suicidal person in order to satisfy the hospital's own administration, because they are obliged to collect the relevant data records. This means that often the professional helpers also want to achieve their own goals or the goals of the organization first.

However, if we know, or assume, that suicide is an action that occurs in the action of carrying it out and not according to a set recipe or instruction, then we must first allow the suicidal person to verbalize and thus also grasp, we sometimes say: apprehend, what has happened. We do this by assisting the person to tell their own story (Michel & Valach, 2011). As we know, a narrative of incidents is presented as a story line of an action process. It is important not to quiz the suicidal person about specific details of the suicide event, but to allow and possibly assist them to independently build or reconstruct their own story of the suicide event. The suicidal person will not only be able to grasp what he or she has experienced, but she or he will also see him or herself as the agent who was at the centre of what happened – even if not all of them can or want to take responsibility. If we compare this with the classical idea of the sick patient who is urged from all sides to passivity, immobility, obedience, and urged to leave the responsibility for recovery to others, we realize that this attitude cannot help a suicidal person. The reader can understand this very well in recalling situations where his own goals were accepted by others involved and yet the others did not quit their cooperation. This is a situation in which we feel that the others want to and can help us, and that a common concern also has a chance of success (Michel et al., 2004).

▶ **Summary**

1. A conversation, or a heard narrative, about what happened is the first step patients take after a suicide attempt to reconcile these events with their intentional actions and integrate them into their life-affirming projects and actions.
2. Two things are therefore built up. On the one hand, the events are seen with the patients' goal-directedness and, on the other hand, a goal-directedness is built up in the patients' actions, which is needed for further suicide prevention projects.

1.9 The Inner Experience in an Action

We all know, lay people and professional caregivers alike, that people have inner lives. Those who write about it, however, differ from each other in their ideas of how these inner processes function and run and how they can be made accessible to others. Some think that the individual parts of the thought and feeling processes are accessible to the agent and that they can be interrogated at any time. Others, on the other hand, are convinced that human beings cannot see into the processes of the true workings of their inner actions and therefore cannot inform us about them. We know, however, or assume from the theory of action and the corresponding research, that the inner processes, which proceed with varying degrees of consciousness, can to some extent be put into language, verbalized, and made accessible. However, this requires a certain procedure that helps the narrator to bring to mind these contents. We use the technique of "self-confrontation interviewing" for this purpose (Valach et al., 2002a, b, c; Young & Valach, 2002).

This technique consists of a film recording of an action or a conversation. This recording is then played back in short sequences lasting 30 s to 3 min, with the request to report thoughts, feelings and sensations experienced during the sequence shown. Not only does this represent a gain of information for the researcher, but this procedure also possesses meaning for the suicidal person and the psychotherapist (Popadiuk et al., 2008), which lies in its multiple effects (Valach et al., 2018). First, the suicidal person becomes more aware of many internal processes through their verbalization, thereby completing the narrated plot. By watching the film recordings of the conversation in a completely different inner state (the pressure of narrating is no longer there, the excitement caused by remembering the reported events has flattened a little, the uncertainty of "how will the listener take this" has disappeared), the narrator can begin to revise the suicidal action with a certain distance. In this process, the experience of pictorial representation is very important, because even what has not been captured linguistically is informative and has a corrective effect (Valach, 2018). This technique and the appreciation of its influence on the suicidal person are also closely linked to the notion of suicide as an action and to the corresponding theory of action. We will address the individual suicidal persons' comments on the influence of the self-confrontation interview in the discussion of the individual stories, because a self-confrontation interview was also conducted for each interview. Thus, it is important to let the patients experience their own suicide story calmly by watching the film recording of their interview and formulating their thoughts, feelings, and emotions about it every few minutes.

▶ **Summary**

1. The inner processes of an action or narrative are captured using the video-assisted self-confrontation interview method.
2. The "seeing oneself" and "remembering the inner processes" exerts a multiple therapeutic and therefore also suicide-preventive effect.
3. It is not only the visualization of certain processes, but also the subliminal experience of one's own actions, which are then consciously or unconsciously corrected in many respects.

1.10 Suicide Prevention as a Joint Project

The notion of suicide as goal-directed action also leads us to see not only the suicidality of the individual in actions, projects, and longer-term concerns such as careers or trajectories, but also to frame life-sustaining activity after a suicide attempt accordingly. The first encounter with the suicidal person, the support in working out the story in which the suicidal person can experience himself again as a goal-directed and meaningful person, the making possible "the furnishing or equipping" of the action through the verbalization of the inner processes already represent the beginning of a joint project whose goal is to participate in life and to commit oneself to one's own life. To engage in such a project together with the suicidal person is the task of the professional helpers, because they cannot fix everything with a magic wand, nor can they abolish the disposition which they often attribute as the cause of suicide. However, in order to develop and sustain a collaborative project, additional steps are needed. First, the suicidal person must develop strategies for how he or she might resolve crisis situations and internally "prepare" appropriate intentions or goals. Second, this common concern must be repeatedly reminded to the suicidal person and trust must be earned, because, as we know from the discussion of the social embeddedness of suicide, many suicidal persons have often been disappointed. Thus, it is important to engage the suicidal person in a joint project of life (Valach, 2020).

► **Summary**

1. Suicide attempts usually stem from a social context, and suicide prevention must therefore be worked out in a social collaboration.
2. The open narrative about what is happening is a first step.
3. To complete the narrative according to inner processes with the patients in a video-assisted self-confrontation represents the second step.
4. The next step is to elicit the patient's existing resources for action and to integrate them concretely into the crisis processes (when, at which point in the narrative, would they do what).
5. Reminding patients about this collaboration, agreed-upon goals, and devised problem-solving strategies over the course of the joint suicide prevention project ultimately helps patients take full responsibility.

Part II

Suicide Cases

Introduction to the Suicide Cases

2

The following discussion of each suicide attempt includes a brief history of the particular suicide attempt and then an analysis of the suicide process using the conceptual considerations presented in the introduction. First, the long-term and medium-term concerns in which the suicide action is embedded are elaborated. Subsequently, the individual actions, partial actions and action steps as well as individual thoughts (cognitions), etc., which the patients describe in connection with their suicidal event are listed with a simplified designation as actions or cognitions. Thereafter, individual conceptually based problematic aspects of the respective suicidal action are discussed. These include the problems of action organization of the suicide process, the question of whether the suicide action was consciously prepared or spontaneously undertaken, problems of action monitoring processes, problems of action energizing, and the social embeddedness of suicide action. Following this, the interview of the suicidal person with the psychotherapists is reproduced in a number of joint actions, followed by a brief summary of the individual sections of the self-confrontation interview.

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Case 1

3

3.1 Suicide Story: Ms. Huber, Who Wants to Please Everyone

Kornelia Helfmann
BerneSwitzerland

Ms. Huber, a young woman in her mid-20s, a student, has an unusually violent argument with her mother one Sunday evening. She throws into her mother's face an accumulation of things that should really have been said long ago. On this day, the straw that broke the camel's back is the fact that her mother has already called several times and then turned up at her house unannounced. Ms. Huber feels monitored and controlled by her mother.

A few months ago, Ms. Huber was left by her boyfriend, and since then she has been plagued by severe lovesickness. Her mother is very worried about her. Several friends have turned their backs on her; they could no longer stand her whining and constant crying. Even a long-time friend, who is like a brother to her, could not help her.

The mother leaves the apartment without a word after the argument. When the door slams shut, the daughter's relief at finally having let off some steam gives way to a terribly guilty conscience. Her mother is her most important caregiver and very vulnerable. Ms. Huber has gotten into the habit of being gentle with her and showing consideration, otherwise her mother might not be able to talk to her for a few days. How could she hurt her like that? She's the only one her mother has. As a young woman her mother came to work in Switzerland from a nearby country, worked as a waitress in a restaurant, met Frau Huber's father and was abandoned by him when she was pregnant. The father is not a permitted subject for discussion, although Ms. Huber would have liked to know a bit more about him. What was he like? What did he look like? Where did he come from? At school, when they still lived in the country, she was teased because she had no father around.

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It was hard enough for the mother when her daughter moved into her own flat 2 years ago. She couldn't understand it; they had a nice flat and enough space, so why did Ms. Huber have to move into this hole? Into a shabby one-room apartment next to the railway tracks, where the trains thunder through and it is only reasonably quiet for a few hours at night? And then, no sooner had she moved out than she had a boyfriend. She'd met him at university, and her mother didn't have a good word to say about him. His clothes weren't clean, he had bad table manners, bossed the daughter around, didn't treat the mother with enough respect, and only needed the daughter for sex because he didn't have money for prostitutes.

It has indeed always been a mystery to Ms. Huber why her good-looking boyfriend was interested in her at all. She likes her pretty face, but she doesn't dare style her hair and clothes a little more jauntily. She always looks a little old-fashioned and she doesn't think her body is well proportioned; the breasts are too small, she worries, the hips too wide. But she's intelligent, and she knows he liked that. And he appreciated that she was interested in art; they went to exhibitions and concerts from time to time. What they bonded over most though was nature, trips to the nearby mountains, hiking. It couldn't have been just the sex that interested him in her after all.

Her mother was jealous. Even though she knew her daughter's boyfriend was staying over, she could call several times in one evening, which was extremely disturbing and pissed Ms. Huber off, and her boyfriend even more so. He accused her of not setting boundaries with her mother and acting like a little girl around her.

Mother and daughter had usually spent Sundays together, but when she had her boyfriend she preferred to be with him. They only had Sundays to be together; on Saturdays she worked in the cafeteria of the indoor swimming pool. The rent and other expenses had to come in, after all. But her mother has hardly any social contacts except with her and at work in the restaurant. She is a timid person, and always having to smile at work is hard for her. Her boyfriend once said looked haggard, a gray mouse who would rather hide in a mouse hole with her daughter. Ms. Huber thought that was a bit strong. But she didn't tell him, because she didn't want to argue with him.

And then this Sunday night. There the mother is, just standing in front of the door, even though Ms. Huber told her she wanted to be alone. The mother starts washing the dishes that have been piling up in the sink for days. Ms. Huber tells her to stop, but the mother just keeps going; she just wants to help her, she says: she couldn't possibly feel comfortable in such a filthy apartment. The daughter stands by passively as the mother then proceeds to vacuum the worn carpet. She feels helpless, powerless even, but when the mother tries to strip the bed, Ms. Huber's anger rises. She grabs the mother rudely by the arm and pushes her against the wall. The mother staggers and her eyes open wide in shock. Ms. Huber yells at the mother to leave her apartment immediately and the mother yells back that she is becoming more and more like her father. This sentence is too much. Ms. Huber is furious and accuses her mother of treating her like a little child, of controlling her, dominating her, taking advantage of her, abusing her. She says that it was all her mother's fault that her boyfriend left her and that she probably wanted to make sure that happened with her constant phone calls. And now she should go away and leave her alone; she has had enough of her.

At first, she is relieved that she has finally told her mother what has been bothering her for so long. The mother cries, picks up her purse and leaves. The daughter stands in the tiny apartment, shivering. Her eyes fall on the mattress lying on the floor. She hasn't changed the sheets since he left her; they still smell faintly of the perfume she gave him at Christmas: Wow! Joop! He had been so happy about it.

She can still remember very clearly the moment she met him. They happened to be sitting across from each other at lunch in the dining hall. She had noticed him before but they hadn't exchanged a word and even now, at lunch, they weren't talking. Not until she knocked over her glass and spilled her coke all over his light-colored pants. He'd just stayed seated and asked her if that was supposed to be a proposition, and she'd said: I guess so. Where she got the courage then, she still doesn't know. Anyway, he came home with her and she washed the stains out of his pants and he sat on the carpet in his underpants for so long. He was cool and she fluttered around him like a nervous chicken, which he was amused by.

They were together for one and a half years. He lived in a shared flat and, for that reason alone, they were usually at her place on weekends. He didn't mind that the apartment was a bit worn out, or that, except for a bookcase, a table with a couple of chairs and a mattress on the floor where she sleeps as well as eats and studies, she had no furniture. The mattress had been the center of her apartment when she was with him; they had made love on it. It was her mattress after all, and her mother had no business messing with it.

Then, after a year and a half, he had left her out of the blue, giving no reason. And that was the worst part for her. That he hadn't even had the decency to tell her why. If she had known, it would have been easier for her, but lacking that, she brooded day and night and yet could find no answer. Had he met another woman? Had she done something wrong, and if so, what? Said something to him that hurt him? Had it been too soon for her to tell him that she wanted a family, children someday? Was it her mother who annoyed him so much? Or had her mother been right after all when she said he just wanted to save the money for a prostitute? The longer she brooded and cried after the breakup (and she cried a lot), the clearer it was to her. Yes, she had been treated even worse than a prostitute by him, because at least they got money for their services.

She's still shaking. She has wronged her mother. It's her fault if she's miserable. What if she's lost her mother now, too? Her last anchor? The one person in this world who has always loved and cared for her? How is she supposed to go on living with this guilt? Does she even have a right to go on living?

Like a tiger in a cage, she runs back and forth in the apartment. She gets a stomach ache; she feels nauseous from embarrassment and has the feeling that she is about to vomit. In the bathroom, she sees her chalky pale face in the mirror. She runs cold water into the sink and scoops it onto her face with both hands.

As she dries her face, her eyes fall on the razor lying on the shelf under the mirror, which her boyfriend left behind. Next to it is a packet of razor blades; he always shaved wet. For a long time she had hoped that this was a sign that he would come back, that he had left these things on purpose. They gave her comfort, but at this moment she feels she hoped in vain. He will never come back.

It's over for good. She'll never have a family of her own. Her relationship with her mother has broken her.

She no longer sees any perspective. She has forfeited the right to life.

She feels like she is outside herself as she slowly takes a razor blade out of the packet. She doesn't feel the first cut in her forearm at all; it's like watching another person do it. It doesn't bleed, either. She cuts herself again and again; still she feels nothing as the razor blade penetrates her flesh as if it were made of butter. She puts the arm into the water in the sink, and slowly the blood flows from the cuts into the water. It looks quite pretty, she thinks. Then she turns the arm and cuts her wrist. She cuts pretty deep and it's bleeding profusely now and it doesn't look pretty anymore. The feeling of being outside herself is suddenly gone.

She doesn't want to die. In a panic, she runs to the phone.

3.2 Suicide Analysis: Britta Huber "I Can't Take It Anymore…"

Ladislav Valach

When asked about her suicide attempt, in her interview with a psychiatrist, Ms. Huber reported short-term actions, mid-term concerns, and long-term concerns in her life that she felt were related to her suicide attempt.

3.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

3.2.1.1 Long-Term Concerns and Medium-Term ('Projects') Concerns

There was a "love relationship" which Ms. Huber's partner ended without giving a reason. She then experienced a period of several months of "abandonment" during which she felt very hurt and unhappy, was desperate and cried a lot. What made her most despairing, she said, was being discarded like a disposable item with no reason given. Even a prostitute is treated better, she said, because at least she gets money for her services. It was not even the abandonment that led to the greatest crisis, but that she had to realize that her "value system, her beliefs" about people and about herself were not valid.

During this time, according to her statements, Ms. Huber was called by her mother about four times a day with the intention of comforting her ("Mother comforts"). However, Ms. Huber experienced this as paternalism, felt "supervised". For a long time she endured this because she did not want to hurt her mother, as this relationship was very important to her. After all, she only had the mother as family, no one else ("relationship to mother"). In addition, Ms. Huber mentioned her "relationship with boyfriend B." for many years, who was very helpful, but had no understanding for her despair and could not help her.

These medium- and long-term concerns are embedded in the patient's "professional goals", which she sees calmly because she trusts her abilities. Her desire is also to have a "family" of her own and it can be assumed that much of what she does is directed towards achieving this goal, e.g. her love relationships. Finally and "vital" is the comprehensive

concern to live, to protect one's own life, etc., which Ms. Huber addresses several times as "I can't anymore", "I am afraid to die", "I don't want to die".

Long-Term Concerns

Some of these long-term concerns are overriding, others are experienced more as equally important, served side by side. However, this order can change. Thus, the self-evidently most important concern "to live" tends to be secondary in a moment of threat to "beliefs and values" (self-worth). These were threatened in the failed "love relationship" when Ms. Huber was left without reason. In the same way, this happened in the moment when the "relationship with mother" was shaken. It was in these situations that the patient felt unable to go on living and wanted to die. Later, when she had the certainty that the relationship with mother was back in order, she was also able to feel confident and wanted to live again. She also suddenly became aware of the importance of her wish "to live" when she was mentally and emotionally in the "here and now" during the suicide action.

Medium-Term Concerns and "Projects"

Within the context of these overarching longer-term concerns, Ms. Huber described some important projects that she saw as relevant to her suicide attempt. It was initially the "ending of the love relationship" with no reason given that caused her to "despair" as this was not in keeping with her belief in the worthiness of people. The period of despair, the constant crying and the impossibility of coping with what she had experienced mobilized the patient's mother, who then engaged in a "project" of "comforting, standing by, supporting", which, however, appeared to the daughter as continuous "surveillance".

▶ **Summary**

1. In connection with her suicide attempt, the patient describes long-term concerns that are important to her or that she considered as an option: they are her life, her beliefs and values, her love relationship, and her relationship with mother.
2. Her medium-term concerns include her coming to terms with the ending of the love affair, her despair, being comforted, stood by or watched over by her mother.

3.2.1.2 Short-Term Actions in Medium-Term Concerns

These medium-term projects were further specified in some common and individual actions that were important for understanding the patient's suicidal action, according to her.

Joint actions (mother and daughter) in the common medium-term concern of "support, comfort, supervision by the mother", in which conflict arose that determined these encounters.

Joint Actions (Mother and Daughter) in the Conflict Project

The "conflict project" is described by Ms. Huber in three common actions "The mother visits the daughter", they "argue" and the patient means to behave in a very uncontrolled and direct way, which she normally does not do and regretted this very much. Thereupon the mother "left the apartment" of the daughter and she remained alone.

Short-Term Actions in the Conflict Project

1. **Visit of mother (M) to daughter (patient (P)).**
   1.1 Action M: Mother visited the patient unprepared.
   1.2 Action cognition P: It's 24-h surveillance.
   1.3 Action verbal M: It is a great burden for me.
   1.4 Action Cognition P: It's clear.
2. **Action: Mother (M) and daughter (patient (P)) quarrel. Subject: lovesickness, feeling watched over**
   2.1. Action P: said many things uncontrolled
   2.2. Action cognition P: (arguing is) unusual in the relationship
   2.3. Action cognition M: is amazed whether negative thoughts
   3. **Action: Mother (M) and daughter (patient (P)) separate.**
   3.1. Action M leaves daughter's apartment: has left.
   3.2. Action cognition P: bad conscience (my action does not correspond to the norm).
   3.3. Action cognition P: my mother is hurt, she suffers.

Short-Term Actions in the Suicide Project

Subsequently, Ms. Huber initiated a "suicide project". She felt she could take no more. After the "suicide (attempt), the patient called her mother" and the "patient was taken to the hospital." After the hospital visit, the patient spent the "weekend with her mother." They were able to have good and "clarifying conversations".

Joint Actions Mother (M) and Daughter (Patient (P))

1. **Suicidal Action of the Daughter (Patient (P))**
   1.1. Action cognition: target P: wants to stop it, I can't anymore
   1.2. Action cognition P: (conflict: she (mother)) means well
   1.3. Action cognition P: but I can't stand it. (Tension with the mother)
   1.4. Action P: went to the bathroom
   1.5. Action cognition P: Look at razor blade
   1.6. Action cognition P: Question: does it hurt when you cut yourself?
   1.7. Action P: Break open the blade
   1.8. Action P: Cut my upper arm, forearm
   1.9. Action cognition P: it does not hurt
   1.10. Action cognition P: looks unappetizing
   1.11. Action cognition P: (it) goes well
   1.12. Action P: watch (me)
   1.13. Action cognition P: it does not bleed
   1.14. Action P: cut at "strategic" points (wrist?)
   1.15. Action P: hold arm under water
   1.16. Action cognition P: there are rings in the water
   1.17. Action cognition P: are pretty
   1.18. Action cognition P: watch (me) (dissociation)

1.19. Action cognition P: Reminder: watched me in the months before
1.20. Action P: cut again
1.21. Action cognition P: it doesn't look nice anymore
1.22. Action cognition P: it is deep enough
1.23. Emotion P: Fear
1.24. Action cognition P: am no longer outside myself
1.25. Action cognition P: if I do nothing, I die
1.26. Action P: apply pressure bandage

2. **Joint Action Patient (P) and Mother (M): Help After Suicide Attempt**
   2.1. Action P: pick up the phone
   2.2. Action P: call mother
   2.3. Action P: ask mother for forgiveness
   2.4. Action P: (ask mother) for help
   2.5. Action P: say that (I) am afraid (of) dying
   2.6. Action cognition P: Mother is not surprised
   2.7. Action cognition M: "stop talking"
   2.8. Action M: Cognition (target) wants to call
   2.9. Action P: hangs up
   2.10. Action M: calls police
   2.11. Action P: run around in a circle
   2.12. Action cognition (goal) P: does not want to die
   2.13. Action M: calls (P)
   2.14. Action M: "should not worry me"
   2.15. Action M: someone is coming
3. **Joint Action (P; Police; Doctors)**
   3.1. Action cognition P: it no longer bleeds
   3.2. Police action: Police arrives
   3.3. Police action: Police press something on the wound
   3.4. Action Police, P: come to hospital
   3.5. Doctors' action: wound was sutured
   3.6. Action cognition P: everything is positive in the end
4. **Joint Action Mother (M) and Patient (P): Spend Time Together**
   4.1. Action M: Mother picks me up at the hospital
   4.2. Actions P: spend Sun and Mon with mother
5. **Joint Action: Patient (P) and Mother (M): Time with the Mother: Conversation**
   5.1. Action P: say I feel guilty (because of what I have said and done)
   5.2. Action P: said: do not know how to apologize
   5.3. Action P: (say) I am very sorry
   5.4. Action cognition P: she understands that
   5.5. Action M: (Reported by action M): she also attempted suicide once in her life (cut at 30; reason: was left by husband)
   5.6. Action cognition P: I did not know that

5.7. Action P: to mother: do not tell my ex-boyfriend
5.8. Action cognition P: it has positive effects
5.9. Action cognition P: Lovesickness remains

Summary

1. The short-term actions described by the patient are part of a conflict project of the patient and her mother and of Ms. Huber's suicide project.
2. Her conflict project includes actions such as: Mother visiting daughter, Mother and daughter arguing, Mother and daughter separating. These are then described in a series of action steps, partial actions and actions (here all written as actions) and action cognitions or other processes.
3. Her suicide project contains the following actions: Suicide action, help from mother after suicide attempt, help from police, doctors, patient and mother spend time together, mother and daughter talk.

3.2.2 Problems of Action Organization

Ms. Huber describes her suicidal action in detail in many steps, as well as other related actions. Those that preceded the suicidal action (the argument with the mother), the time afterwards, how the patient received help and how she was subsequently able to clarify some things with her mother in good conversations. In addition, she presents her action steps and actions in the context of overarching, broader medium-term concerns, such as the period of despair following the termination of the romantic relationship, regular contacts with her mother in which she felt incapacitated and monitored, and finally the events surrounding her suicide. The patient describes these experiences as belonging to long-term concerns, such as partnership relationship, relationship with her mother, her beliefs, her professional ideas and then also the concern for her life.

The short-term actions, medium-term concerns and long-term goals and processes can be seen in a system context. In the actions the superordinate processes are lived out and materialized, in the superordinate the meaning of the actions is anchored. The actions are performed in the service of these superordinate processes. Accordingly, the action of suicide is also to be seen in a systemic context. Therefore, a number of processes at different levels of the hierarchy are involved in the suicide action. Certainly the "abandonment", the "threat to the relationship with mother", the "presence of the razor blade in the bathroom", the "ability of the patient to dissociate" and many others are to be counted among them. Last but not least, the patient's experienced "disregard for values and beliefs" is also implicated in her suicide. We described suicidal actions as flawed actions. Again, we see that overarching important projects and concerns are forgotten or disregarded for a time. It is primarily the goal of staying alive that takes a back seat. Moreover, one might wonder why the threat of straining the relationship with the mother degenerates into an existential

crisis. The mistakes made in the interaction can be clarified in a subsequent discussion, which the patient did later with her mother. It would be quite conceivable that the mother, coming from another country, leaned very closely on the patient and that the latter did not dare to disappoint her. One would have to ask similar questions regarding what happened following the broken off love affair. One might ask whether the patient had already experienced the "abandonment" of a primary caregiver, at an age when this was experienced as existentially threatening, or whether such an episode was told to her by her mother. The fact that the patient's father did not feature in her narrative might suggest this. Such events, however painful, should not become an existential crisis in adult life. That is, the adequate action, the optimal action steps in such a situation look different. Further, the fact that one "can't take it anymore" does not necessarily have to lead to suicide and be inspired to cut by razor blades. Time off would certainly help to regain motivation and strength. These are all problems in the order of action, in which – taking into account the overriding interests and with the participation of the adequate inner processes – the goal-directed steps of action should be chosen.

However, according to action theory, the sequential-hierarchical order of the goal-directed processes of this patient and the person involved is not the only crucial thing to be examined in the analysis of suicide processes.

In action, the action control processes must also be taken into account.

► **Summary**

1. The concern to cope with "abandonment", "threat to relationship with mother" and "disregard for values and beliefs" led the patient to give up her life. That is, the concern "to live" was seen as subordinate to these other concerns rather than superior to them. This is an example of the patient's problems of action organization.
2. Another problem in the organization of action is represented by the association of the thought "I see no way out" with the perception of razor blades, which suggest to the patient a means of achieving her goal.

3.2.3 Consciously Prepared or Spontaneously Undertaken?

The suicidal action must be seen in a systemic context. The question arises how the patient changed from her life-affirming projects to the suicide project, in which the suicide action then took place. Her project of "partnership" was broken off by her partner and he left her. Ms. Huber was in a phase of "abandonment" at the time of the suicide attempt, in which she cried a lot and felt hurt and offended. Not only did she believe she had to give up her goals of "having a family," but she also felt let down in her most important "beliefs about valuing a human being." In addition, and this came later, she felt that she was incorrigibly damaging her "relationship with her mother" in her uncontrolled blowing off of steam. We

must surmise that the young woman identified her life with having a good relationship with her mother, with holding a person in esteem in relationships and partnership, and with her desire to have a family. Her concern to "live" per se without these circumstances and conditions did not seem to exist for her as an independent project. The patient reported stages and increasing specificity of her shift to suicide project and suicide action. First came the "dropping of the life project" ("I saw no way out") and then the "presence of the razor blade" in the bathroom offered a self-harming action that she felt like a way out. However, going to the bathroom already signifies a conclusion to a number of goal-directed processes, such as initiating the end of the day (evening toilet), concluding the sleep process (the morning toilet), completing food intake and digestion with a voiding, concluding an activity with hand washing, etc. Therefore, this walk as a process of change from life projects, can mean the completion of life projects. Lastly, her "trained" "ability to dissociate", to observe herself and not feel pain allowed her to take the critical step of performing the suicidal action. The disrupted order of the control processes can also be seen in the lack of testing of the action initiated by a perception of the razor blade, as the goals were not tested for compatibility with other important goals.

► **Summary**

1. The decision as to whether a suicidal action was prepared or spontaneous, top-down or bottom-up, can often be answered, as in the case of Ms. Huber, with as well as.
2. The patient decided to give up on life as she saw no way out (from the top down).
3. However, she was only encouraged to cut her arm in the bathroom when she saw razor blades (bottom-up).

3.2.4 Problems of the Action Monitoring Processes

Self- and action-monitoring systems include attention or awareness, emotion, and pain. In analyzing interviews with patients who survived a suicide attempt, we found that these self and action monitoring systems functioned incompletely or incorrectly. Ms. Huber also describes some action processes that include self-monitoring processes that could be described as faulty. First, there are the relational crises that the patient monitors as existentially threatening. We argue that in such moments, when these keys are drawn, our emotions do not come from a reflection of the immediate situation, for which they are ideally suited, but a feeling is drawn from memory, with which a false picture of the situation is then created. In the suicidal action itself, the patient describes her self-monitoring processes as "watching herself," "being out of herself," and therefore not signaling pain and threat. It was only when the patient was back in the "here and now" with her thoughts and feelings that she was able to realize the consequences of her actions and stop the self-harming action that could lead to death. The patient also reported that in her despair she

was shunned by her acquaintances and friends. This could also be taken to mean that the patient does not behave appropriately to the situation and rules in such encounters with her acquaintances, for a general inability of others to sympathize cannot be assumed. This is also an action-monitoring problem.

Summary

1. Ms. Huber's action monitoring was shown to be disturbed on several occasions in connection with her suicide action.
2. She felt no pain as she cut her forearm with the razor blade.
3. She held her emotional memory for the present emotions to mirror her current situation.
4. When cutting, she observed herself from the outside, instead of directly and immediately "experiencing" what was happening in a participatory way.

3.2.5 Problems of Action Energization

The function of energizing is provided in a short-term action by emotions. Ms. Huber reports about energizing processes in her description of the suicide action. In her discussion with her mother, she says, "…I said a lot of things to her that I thought shouldn't be said, but it just came out like that, so pressure cooker-like." She makes us understand that in that moment her emotions, her energy, decisively shaped her interactive action and took over. She could no longer behave in a polite and controlled appropriate manner as she usually did, "I usually know how to be critical with my mom. Sorry, my mother is a person who doesn't take criticism very well, but if you package it nicely, you can bring it up now and then." When the mother left the patient immediately afterwards, the young woman experienced strong emotions, "I knew I had caused her more pain now. It just hurt so much, and I just wanted to know if there was a way to stop the hurting. And I didn't feel like it anymore; I'd been crying for months and now this; she only meant well, after all. I just didn't have a way out. I just couldn't take it anymore." With these feelings of aggression on the outside and psychic pain as energy, but no energy or desire to live, Ms. Huber went to the bathroom where she saw razor blades. She began to cut herself, and when the wound began to bleed profusely. Great fear, a feeling with a lot of energy, overtook Ms. Huber, and she began to act to save her life: "Afterward, fear got a hold of me." Then, when she called her mother, she experienced mortal fears. These energized her to such an extent that she ran aimlessly in circles to get rid of this energy: "I ran like mad in circles, in my room, in the study, always running around in circles, like a horse that has flatulence. I just didn't want to die." The energizing processes can also be observed in medium-term and longer-term concerns. Ms. Huber shared her despair that caused her to cry for months after being abandoned. In addition, she was driven to shape encounters with her acquaintances and friends in ways that cost her some friendships, as people tried to avoid the subject and even the patient herself.

Summary

1. The patient describes her energization of action especially in destructive actions.
2. In an argument with her mother, she felt herself "exploding like a steaming pot."
3. After being dumped by her boyfriend, she spent months in a state of despair. An energization that she could not translate into any constructive actions.
4. When she became panic-stricken after the suicide attempt, she had to act out her sudden energization in stereotypical actions, running around in circles.
5. She was then energized into constructive action when, after cutting, she saw her blood, got scared, stopped cutting, and asked her mother for help.

3.2.6 Suicide and Interactive and Joint Action

Suicide is a personal decision, in which, however, others and the environment can also have a say. Thus, in most cases, help is given to a suicidal person, even against his or her wishes (with certain exceptions). Nevertheless, we pointed out that suicide is usually embedded in relationships with others and therefore the social aspects, the joint actions of the suicidal person with others, would have to be understood. This is also the case with this young woman. She reports her ended love relationship in the context of her suicidal action. She describes her involvement with her mother, which was unhappy for her, and how she found the upheaval in her relationship with her mother to be existentially threatening. After the aborted suicide action, the patient re-establishes contact with her mother, who continues to help her. The patient is attended by the police and treated in hospital. She then spends the weekend with her mother, with whom she also has many clarifying conversations, which she experiences very positively. The patient also counts her encounters with her colleagues and friends when she was desperate as part of her suicide experience. Ms. Huber experienced them as either avoiding the topic of abandonment, which was very much on the patient's mind, or as avoiding the patient. She also tells of her best friend with whom she could talk well but did not feel understood because he could not properly appreciate the depth of her hurt. We pointed out that the most important relationships in the suicide event should be harnessed for suicide prevention.

In this context, that suicide processes are social processes in their origin, their course, their consequences, our prevention efforts must also be seen. The encounter of professionals with suicidal people is very important, and much attention must therefore also be paid to the design of this encounter. How did Ms. Huber's encounter with the psychiatrist turn out?

Summary

1. The patient was alone at the moment of the suicide attempt, but counts her relationships with others as belonging to her suicide.

2. She has an intense relationship with her mother, with whom she argued immediately before the suicide attempt because she felt she was being monitored by her.
3. The patient's boyfriend ended their relationship without giving any reason for this and thus hurt the patient very much. She felt very disappointed in her ethical principles.
4. The young woman felt misunderstood and left alone by her best friend in her grief.
5. Immediately after the suicide attempt, Ms. Huber called her mother, who then went for help. The patient found the subsequent conversations with her mother very helpful.

3.2.7 The Young Woman's Conversation with a Psychiatrist

Ms. Huber's story is not an uninvolved, neutral recording of what happened, but comes from a conversation with a psychiatrist about her suicidal action. This story is therefore shaped by the relationship and also by the interlocutor, by the questions and follow-up questions he asked.

The conversation, jointly designed by Ms. Huber and the psychiatrist, involves several parts, several joint actions.

1. The psychiatrist introduces the **first part** with the open question to describe what happened and how it came about. Ms. Huber accepts this task, and so the description becomes the common goal.
2. Joint action: After the last action step of the suicide episode described by Ms. Huber, she briefly tells about her mother's suicide attempt. The psychiatrist shows interest in the topic, and so this exchange becomes another joint action.
3. Joint action: The psychiatrist tests his hypothesis as to whether the broken-off love relationship or rather the relationship with the mother was the decisive factor for the suicide. Ms. Huber provides information on the relevant issues and also confirms the psychiatrist's conclusion.
   (a) Psychiatrist asks about the mother relationship
   (b) Psychiatrist asks about love relationship
   (c) Psychiatrist: Conceptual summary of relationships
4. Joint action: Psychiatrist wants to explore plans for the future. Ms. Huber, however, only takes up the subject insofar as she again speaks of her relationships and relationship problems.
5. Joint action: As Ms. Huber arrives back at her relationship design, the suicide problem is discussed. The psychiatrist probes for the moment of origin of the suicidal thought and for other options. In addition, he wants to know if not only suicide but also death was present as a goal. The young woman accepts this task.
6. Joint action: closure.

These common actions can then be seen in a hierarchical order of superior and subordinate units. In an interview situation, it is above all the questions of the psychiatrist and answers of Ms. Huber that are decisive for the individual action steps. In order to ensure an orderly description of action, open questions are suitable, which are oriented towards the rules of everyday descriptions. The follow-up questions should also be asked in such a way that they do not disturb the flow of the description. If Ms. Huber is oriented towards the passage of time, follow-up questions about the next step in terms of the patient's history are appropriate; if she is oriented towards a continuity of feelings, questions about the shading of these feelings are helpful. The psychiatrist behaved accordingly in the conversation with Ms. Huber.

► **Summary**

1. The conversation about a suicide attempt is composed of several joint actions of the psychiatrist and the patient.
2. The psychiatrist wants to have an open conversation in which the patient's narrative can unfold. He defines the task: to describe the suicide event and how it came about, which the patient accepts. An additional goal is then formulated in the conversation: what the patient's ideas for the future are, a task which the patient, however, does not take up.
3. The psychiatrist's inquiries are guided by his implicit ideas about suicide: was it the relationship with the mother or the relationship with the boyfriend that was decisive for her suicidal action? (He does not ask about the position of the moon on the night in question or about the person's horoscope sign).

3.2.8 The Self-Confrontation Interview

Telling the story one has experienced in a conversation (a few days after a difficult situation, such as a suicide attempt) with an authority figure such as a psychiatrist, whom one also does not know, is not only a difficult task, but also a complex one. It is therefore not surprising that not everything that belongs to the story in terms of inner processes, nor what one experiences in terms of feelings and thoughts in the conversational situation, can be brought up. We therefore videotaped the conversation and showed these recordings in short segments to the patients. They were asked to tell everything they experienced in terms of thoughts and feelings in the 2–3 min of recordings shown.

Ms. Huber says about the **1st section** that although she had already said everything she thought or felt around the described action in this section. However, she had doubts about disclosing what she had experienced with her mother in the conversation. She struggled with the feeling that by doing so she was attributing some blame to her mother for her existential crisis, which she did not want to do ("How can I say it without it then being negative"). Because she knew that her mother only wanted the best.

In the **2nd section,** Ms. Huber discusses her relationship with her mother and says that she does not want to hurt her, not because it is rude, but because she loves her very much. While she mentions in the interview that her mother is the patient's whole family, she presents this differently in the video self-confrontation. She mentions that the mother comes from abroad, has no relatives in Switzerland and that Ms. Huber therefore represents her mother's whole family. The young woman also says after viewing this section: "It is actually irrelevant how I was brought up and the ideals that my mother had in my upbringing. That ultimately doesn't play into this, and if it does, it's on the margins." We do know, however, that this played an important role in Ms. Huber's suicidality, as she was unable to cope with the violation of her values, beliefs, and self-worth.

In the **3rd section** where the patient described her suicide action steps, she experienced this as difficult. Because she knew that what she had experienced was described as a mental disorder: "I had maybe started to put myself outside of my body because of all the grief", which she wanted to communicate truthfully.

Ms. Huber experienced the **4th section** as exhausting: "It was exhausting insofar as I was somehow looking for the right words and on the other hand because I know that it sounds kind of crazy. It just sounds strange when someone says that they stand outside themselves and watch themselves. That is already not the "norm case"".

She also describes the difficulty of believably portraying how at first she was not afraid of death, which did not seem normal to her, and then how she suddenly became afraid of dying.

In the **5th section** the patient tells about her experience of the feelings during the conversation. She means blushing because: "that's when it came up again. There was really still some of the fear there."

Ms. Huber says to the **6th section** that she feels relieved. She had been relieved when the police came and she also felt this relief during the conversation with the psychiatrist.

In the **7th section,** Ms. Huber reflected: "whether I can tell it at all, because actually it's my mother's private affair" (her mother's suicide attempt when she was 30).

Regarding the **8th section,** Ms. Huber says: "Yes. There I had the feeling that the psychiatrist had not understood. I had somehow, how shall I say, almost like the feeling Now it's my mother's fault then." She then wanted to put it right.

Ms. Huber thinks that she had thought about the topic of the image of man and the image of the world in the **9th section.** She could not elaborate on her thoughts because this would have taken a lot of time ("I really slowed down there…"). However, this was very important to her, and it was also important for understanding her crisis.

In the **10th section,** Ms. Huber addresses the psychiatrist's behavior ("I noticed that he was enumerating, and that's when I made an effort to explain everything in a nice enumerable way").

In the **11th section,** Ms. Huber felt understood. She experienced a: "Relief actually. It's understandable to someone after all. Because it's still important to me that if someone's already talking to me, at least they're still hearing the right things."

The young woman states that she felt irritated in the **12th section** because the psychiatrist used the term "relationship project". She found this inappropriate.

Regarding the **13th section,** the patient says that although she talked about professional goals, she knew at the same time that other things, such as showing herself humanly to her fellow human beings, were more important to her ("I really believe that you have to try to behave humanly and behave well towards your fellow human beings. And then it doesn't matter if you have a university degree or if you live under the bridge. I think that's more important.").

In the **14th section,** the patient believed she had to defend her mother ("Again, I feel like he (the psychiatrist) is attacking my mother." "…She really didn't deserve any criticism."). She also remembers realizing she had blushed.

Regarding the **15th section,** Ms. Huber says she was annoyed that she brought up her long-time good friend, even though he had nothing to do with the whole affair.

► Summary

1. The self-confrontation interview allows the patient to be more precise about her conversation with the psychiatrist (not: my mother is my whole family, but: I am my mother's whole family).
2. The patient speaks of feelings that she experienced in the interview and that she did not verbalize there: her doubts, how difficult she found certain passages of the narrative, how exhausting this was, how she experienced her fear and also relief, and how she was annoyed to have touched on certain topics.
3. The patient also tells about her thoughts during the interview: she thinks about whether she can tell something, she thinks about the problem of the image of man, but she thinks that it is not enough to present it and that it is more important to show oneself human than to pursue a professional career.
4. The patient also tells about her perceptions of her counterpart: "He didn't really understand", "He enumerates, and so I want to tell it in an enumerable way", "He understands now", "It irritates me when he talks about a relationship as a relationship project".

Case 2

4

4.1 Suicide Story: Mrs. Meier in a Vicious Circle

Kornelia Helfmann
Berne, Switzerland

When she wakes up that Saturday morning, the bed next to her is empty. Her husband has not come home. On Friday night he'd told her he still had to go to the office. It could be late, he said. When she went to bed around 11 p.m., he wasn't there yet.

Her first thought is: he has had an accident with the car. It was very slippery last night. Freezing rain. In a panic, she runs outside, but his car is not there. Without knowing why, she opens the mailbox. Maybe it's because she suspects something, and there is indeed a note inside. It's from her husband. "Dear Susanne, I'll come tomorrow, you'll find out more then." She stands in front of the letterbox, her hands trembling. She feels as if the ground were being pulled out from under her feet. Now it's happened, she thinks. Now he's left me. It's been clear for a while that he can't stand the situation any longer.

What did he mean by tomorrow? Did he post the note last night, meaning he will come today, or did he post it today and will therefore not come until Sunday? She can't stand the uncertainty; the uncertainty drives her to despair. Back at the apartment, she calls him, but he doesn't pick up. She tries again and again, leaving him a voicemail to please call her back. She can't stop her voice from almost rolling over in panic.

In the living room, she drops into an armchair. Her eyes fall on the only two photos hanging above the sofa. The first is her wedding picture: a happy bride and groom. Her husband has put an arm around her waist and pulled her close; they look into each other's eyes in love. Next to it: a photo from their vacation in Italy. They are sitting in a restaurant on the beach, toasting each other, red wine in their glasses, pizza on their plates. All was

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right with the world then. Her husband had fallen in love with a happy, vibrant woman who was so adventurous that he teased that she was a little volcano.

That's all so far away. There's nothing left of it now. When did it start? When he worked so much? Left her alone so often she was afraid of losing him? When he didn't want to talk about it, got defensive when she brought up her insecurities?

The phone rings. He still needs that day, her husband says. He is in a hotel but he will come on Sunday evening. His voice sounds monotonous, as if he is reading from a piece of paper. Now, at last, she's sure it's all over. He will come tomorrow to tell her that he is moving out, that he can't stand this life anymore. How will she go on living without him? What is life without him? What will she have left?

She knows how much of a burden she is to him, has been for years, ever since she had this disease. She is also a burden to her parents; they worry so much about her. She hasn't seen them in a long time. She can't stand visitors and no one visits her anymore anyway. It is just not possible. Her day is meticulously scheduled; it's all about food, finger down throat, food, finger down throat. Up to three times a day. If her husband comes home late at night, then again. It's a vicious circle she can't get out of.

Her strength is only sufficient to manage the household more badly than well. She has not been able to work for several years, although she always enjoyed her job as a kindergarten teacher. Eating, vomiting, eating, vomiting, controlling her weight: all her energy goes into that. If she gains a hundred grams, her world collapses. Climbing stairs gives her trouble; her legs are so heavy, she's just tired. Wimpy. Huge brown eyes in a pale, haggard face. Her once beautiful brown hair: thin as string. Stern lines etched around her mouth. How long has it been since she laughed? She can't remember. What's a man to do with a woman like that? Is she even a woman anymore? Her menstruation stopped a long time ago. Her interest in sex too. She just wants to be left alone. She's ashamed of what she's doing to her husband.

In the kitchen, the parrot is whining. It sounds like the crying of a child. He still has the cloth over his cage, and she hasn't given him his food yet. This whining irritates her. She goes into the kitchen, drags the cloth to the floor, and yells at him to shut up, damn it. The parrot looks at her helplessly with his yellow eyes. Uncomprehending. Immediately, she is sorry. She feels ashamed. He doesn't deserve this, her yelling at him so often. She's become really angry, has no more patience. She hasn't played with him for a long time either; the animal is completely neglected.

She takes her shopping bag and goes to the supermarket. Beforehand, she has made sure that there are enough pills and that she does not have to go to the pharmacy. The toiletry bag, disguised as a cosmetics supply, is still there and well stocked. Sleeping pills, pain pills, and more medication. She prepared this 6 months ago. In case a situation like today should arise. She's also talked to her husband before about how she envisions her funeral. It's been a while. Two, three, years ago maybe? They didn't live here and she was hoping that one day her body would go on strike and she would die a natural death, that her heart would fail or her kidneys. Unfortunately, that didn't happen. So he definitely knows that she doesn't want to be buried here in the village, but at home. That is, where she was born and

raised and where her parents still live today. She can still remember seeing the cemetery very clearly in front of her and feeling extremely guilty when she talked about it with her husband at the time. What were her parents supposed to tell people? Our daughter's heart just stopped beating? Or the truth: she starved herself to death? I don't think so.

In the hallway she meets the neighbor, who greets her amiably. She greets back briefly, looking at the floor. No contact, please, with anyone. She doesn't even know the names of the people who live in this house, yet they have been living here for a year and a half. At the supermarket, she flits from shelf to shelf, preferring not to be seen and possibly approached. Back home, she unpacks the groceries and puts them in the fridge, mechanical as a robot. Allowing no thoughts, no feelings. She takes the pills into the bedroom, places them on her nightstand. This time she will summon the courage. For sure. Then she eats breakfast. Some fruit and yogurt, as usual. Then she cleans the parrot's cage. That's all there is to it that day. Except eat, vomit, eat, vomit. And then, as always, standing in front of the toilet crying and asking herself, why am I doing this, why?

In the afternoon her mother calls, but she does not answer the phone. Her mother can't know she's alone, she'll have to think she's taking a walk with her husband. You see, they have an agreement. When her husband is away for a long time, on a business trip or on military duty, her mother always calls in the morning, lets the phone ring twice, hangs up. And then she calls her mother back, lets the phone ring twice, hangs up. To let her know she's alive, that she has not had a heart failure, for example. That no one has to look after the parrot.

She hasn't told her mother that she hasn't been going for walks for a long time. She would only worry more about her daughter. She is the only one in the whole family who has had a mental breakdown. It must be bad for her parents; they live in a village where everyone knows everyone, people whisper. She is sorry for what she has done to her parents with her illness; she has always been very ashamed of that too.

Somehow, Saturday goes by. As evening falls, she panics. What if her husband doesn't come tomorrow after all? What if he just said it to calm her down? She'll have to think of something to do about the parrot. The poor innocent animal can't be allowed to starve because it's no longer being fed. She knows just how to lure her husband into the house. He really wanted her to go to therapy and made two appointments for her, which she then didn't keep. But she just can't imagine entering the hospital and going to therapy. She even panics about having to eat on a set schedule and not having a chance to vomit afterwards. These cancellations and her just not wanting to be helped were probably what triggered her husband to break up with her. That's when the last spark of hope was extinguished.

She calls her husband and leaves him a voicemail saying that she has decided on therapy and can enter the hospital as early as tomorrow morning. She asks him to come by in the afternoon and give the parrot its food. It's a lie. Although it comes easily to her lips, she's ashamed of it, but at least this way she can be sure he'll come.

She puts the parrot's food in his cage and covers it with a cloth. That way he will find his breakfast the next morning. She puts the dishes in the dishwasher, cleans the sink, gives water to the green lily on the windowsill. It's the only plant that survived. They used to have a lot of plants in their home. It was just part of life for her; it was important to her to

have an inviting, comfortable home. When they moved last time, they had already run out of energy for that. Their beautiful furniture was just dumped into the apartment; one plant after the other died; the pictures were not hung; the curtains are still in a box in the basement. Only the two photos, their wedding photo and the one from their vacation, found their way onto the otherwise bare walls. It was her husband's only contribution to the beautification of the apartment. Actually, he could have done more. But he preferred not to spend his free time at home on weekends.

Her cell phone rings in her pocket. It's her husband. He wants to make sure she's really going to enter the hospital tomorrow morning and start therapy. His voice sounds skeptical. It's easy for her to lie to him. Yes, she wants to start therapy, she says. A place has become available at the hospital at short notice. He promises to come in the afternoon and feed the parrot.

She heats up water and fills two hot-water bottles, then she takes a large water glass from the cupboard and turns off the light in the kitchen. Goes into the bedroom, puts the hot-water bottles in the bed and goes into the bathroom. Fills the glass with water, brushes her teeth, goes back into the bedroom and puts the glass next to the tablets. Takes off her clothes, folds them and puts them on a chair. Puts on her pajamas. Sits down on the edge of the bed. Squeezes one sleeping pill – they're blue – after another out of the foil and swallows them, takes one pain pill after another until the whole pack is empty, and more from a tube, keeps taking sips of water. It goes quite easily. She is quite calm. Only once, after all the sleeping pills are swallowed, does she wonder what she is actually doing, and whether she should actually get up now and call 911 to get her stomach pumped. But it is just a brief thought, a flash of inspiration that goes away as quickly as it comes. Then she just keeps going. In all, she takes 20 sleeping pills and about 30 pain pills. That should be enough, but, just to be safe, she's also taking all the other pills available: an antibiotic; the remedy for her sun allergy, and others whose uses she doesn't know, but she doesn't care. She just wants to be sure that she won't wake up again: that she will never have to live a life without her husband and that she will finally have her peace and the vicious circle will stop.

She turns off the cell phone, lies down, and turns off the bedside lamp. It's warm in bed. She always liked going to bed; it was the best part of the day. One hot-water bottle against her back, the other on her stomach, pulling the covers up to her chin, snuggling in. Then closing her eyes and sleeping. Today she can't manage to fall asleep, despite all the pills. Her heart races; she hears the throbbing in her ears. Then the film tears.

4.2 Suicide Analysis: Mrs. Meier "I Can't Imagine Life Without Him…"

Ladislav Valach

Mrs. Meier, visibly underweight, describes in a conversation with a psychiatrist how she struggled unsuccessfully with her eating disorder and had wished to die for some time. She hoped her heart couldn't take the starvation and would give up, which didn't happen. Her

marriage was under severe strain, not the least of which was her change in behavior, her irritability. When her husband informed her that he could no longer stand it and was moving out of the apartment they shared, Mrs. Meier took the overdose of medication she had been preparing for a long time and did not wake up until she was in hospital.

4.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

4.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

The patient describes in detail the preparations for her suicide on the critical weekend. For about 2 years she has had the wish to die. In addition to the medium-term concern of weakening her heart by starving so that it gives up, she links her suicidal action to further, longer-term concerns. It is first her marriage, or her relationship with her husband. While on the one hand she feels she cannot live without him, on the other she holds him partly responsible for her hopeless condition, although she acknowledges that he suffers greatly from her "eating disorder." Besides this, her relationship with her parents is also very important to her. She is ashamed of what she did in front of her parents, regrets that she could not see them anymore because of the complicated daily routines of eating and vomiting. It is mainly her "relationship with her mother" that concerns her greatly. The mother had felt powerless and suffered from the lack of understanding in the village for her daughter.

Mrs. Meier reports her "death wishes" in different contexts. A counterpoint to the agonies of the day (the eating and vomiting) was represented by her ritual of "lying down in bed," the moment she describes as the best of the day. Because she coincided this moment with her suicide attempt, she was able to face it with less anxiety, even if sleep did not come immediately after the overdose as expected. Her relationship to life and her desire or long-term concern to "stay alive" comes through especially when she finds herself in the hospital and her husband visits her. She identifies her "staying alive" with her "relationship with her husband." She could not live without him and when he wanted to leave her, she took the overdose that had been prepared for a long time. She feels that the suicide attempt represents a period in her life that she would like to undo, it must never happen again. Also of importance is the patient's "relationship with her bird." When she made preparations for her suicide, her main concern was that the bird did not starve to death. She even lied to her husband about it.

There was practically no relationship with acquaintances and neighbors. The patient could not make any visits, and besides, they had only been in their present place of residence for a year and a half. Such non-existent relationships, however, are a part or a result of the longer-term concern of "avoiding social contact." The patient's eating disorder also involves at least a medium-term concern of "treating the disorder." This is a common concern, as above in all likelihood many others, such as marriage, recreation, housing to planning her funeral. The husband signs the patient up for treatment, she fails to attend appointments, imposes certain conditions, such as how admission to the clinic must be

arranged in order for her to enter, and finally she lies to her husband that she is entering residential treatment. After her suicide attempt, shame had been her dominant emotion. One could assume that this stems from her long-term effort to "do everything right" and "be a good person", which she was unable to achieve in her eyes.

Long-Term Concerns

How are the patient's long-term concerns ordered? The highest goal of "staying alive" has been subordinated to other concerns by the patient for some time. Her eating disorder-related "starvation and vomiting," which she pursues with a "desire to die," is more important to her than "staying alive." The patient also allows us to understand that she identified the long-term concern of "staying alive" with the "relationship with her husband" that developed later, and that she consigned this relationship to "her own life." Moreover, she cannot stop her eating disorder, her "starving and vomiting" or subordinate it to the "relationship with her husband". She is aware that this puts a lot of strain on living with her husband and understands that this is not reasonable for her husband. However, she is unable to give the concern "to recover" the importance it deserves and disregards the relevant treatment arrangements. How weakly the patient was able to pursue the long-term concern "to stay alive" was shown during the suicide attempt. While taking each tablet, the thought, which she describes as a flash of inspiration, occurred to her only briefly that she should possibly call an ambulance to pump her stomach. However, it was only a flash that did not become actionable. She describes how the concerns of "starving and vomiting" were perpetuated by everyday routines, behind which she was unable to perceive and articulate her goals. She speaks of "panic fears" that she would have to endure if she could not maintain her "eating and vomiting routine". She gets to the heart of it when she says she found herself in a "vicious circle" that she could not escape. The concern of "avoiding the panic fears" therefore seems to gain the highest priority among her long-term concerns.

Medium-Term Concerns and "Projects"

Within the long-term concerns, such as the relationship with the husband, the preoccupation with death, relationship with the mother and the family of origin in the home community, but also the long-lasting eating disorder, the patient undertook some short-term projects that are closely related to her suicide attempt. Her "fight against the clinic treatment", which became an important element of the relationship with the husband, played an important role until the last moment before the suicide attempt, because the patient knew that she could lure the husband home with her promise to enter the clinic. Likewise, the "preparations for suicide" represent a medium-term concern, in which the patient had been collecting medicines on her travels for 6 months in order to use them to commit suicide. However, at the center of the patient's narrative is her "suicide project".

► **Summary**

1. In her description of the suicidal event, the patient expresses a hierarchy of her long-term concerns. Most important to her is "avoidance of panic fears", then comes "starvation and vomiting", followed by "relationship with husband", and only then comes the goal of "staying alive", which is abandoned in view of the other unachieved goals.
2. The suicide action itself is embedded in her medium-term project "fight against hospital treatment" and her "suicide project" and "preparations for suicide", as she has already been collecting overdose medication for several months.

4.2.1.2 Actions in the Suicide Project

Implementation of the Suicide Intention

Cognition P: I have been carrying it (desire to die, suicidal thoughts) around for a long time.
Cognition P: All that was missing was the last straw that broke the camel's back.
Cognition P: I thought about it a lot, but never had the courage.
Cognition P: Due to my illness, 1 day my husband could no longer.
Cognition P: He was also stuck in this vicious circle in his own way, so 1 day he wanted to move out.
Cognition P: That had been the deciding factor for me.
Cognition P: I can't imagine life without him. ◄

Suicidal Action Patient (P); Husband (E)

Joint Action (Patient (P), Husband (E)): Husband Withdraws

Cognition P: Friday it started like this….
Cognition P (action step E-P): That's when it started, he still had to go to the office and said it was getting late.
Cognition P (action step E-P): He still has to finish something.
Action step P: I waited until about 11 o'clock.
Action step P: Then I went to bed.
Action step P: Saturday morning when I woke up, he wasn't there.
Cognition/Emotion P: That's when I got really scared (mad).
Cognition P: It had been slippery and so I thought he had had an accident.
Action step P: I then went to see if the car was there anyway.
Cognition P: But there was nothing there.
Action step P: I then opened the mailbox by chance, where I found a note.
Cognition P: It said that he would come tomorrow and I would find out more then.
Cognition P: That made me think a lot.
Cognition P: Now did he mean anything by "tomorrow"?
Cognition P: Did he throw the letter in today and mean Sunday, or did he throw it in on Friday and mean Saturday?

Joint Action Patient (P), Husband (E): Husband Informs that He Will Move Out

Action step P-E: He has a cell phone and I left a message to him on it.

Action step P-E: He should just ring back to me to give me a clearer picture.

Action step E-P: Then he also called me (in the morning before I went to the village) and said that he now needed this day.

Action step E-P: He wrote me a letter.

Cognition P (action step E): (he told me there) that he just couldn't take it anymore and that's why he's leaving now.

Cognition P (action step E): He had spent the night in a hotel, but promised to come over on Sunday evening.

Actions P: Patient Does Household Chores as Usual

Action P: I then did the housework as I do every Saturday.

Action P: Then I went shopping.

Action P: Still cleaned the bird's cage.

Actions (P): Prepare, Check Overdose

Action step P: I just checked to see if I had enough.

Cognition P: I actually got ready at that time… maybe 6 months ago. (getting ready for the first time).

Action step P: I also went to see if I still had all the material that I had put together a long time ago, or if I had to go to the pharmacy first.

Cognition P: I then saw that everything was still there as I once had it ready.

Cognition P: So that was my first suicide attempt on Saturday.

(Joint) Action of Patient (P), Husband (E): Protecting the Bird from Starvation After the Patient's Suicide

Action step P: I already suspected it, then found it (note) on Saturday night about 9 o'clock.

Cognition/Emotion P: And after that came the fear that he wouldn't come on Sunday night.

Cognition P: Then I had to think of something to make sure he would come for the bird.

Cognition P: Otherwise, the bird would starve to death if it didn't come for a week.

Cognition P: Then I saw the only possibility in that.

Action step P-E: That I left a message to him again on his cell phone and lied to him.

Action step P-E: I said that I had called the hospital and I could now enter therapy on Sunday morning.

Action step P-E: He should therefore come during the afternoon to give the bird the food.

Cognition P: Then I was sure that he would come, and that the bird would then be taken care of.

Cognition P: Because then if he didn't come for a week….

Actions Patient (P): Preparation for the Next Morning

Action step P: In the evening I put the food for the next morning into the cage.
Action step P: Yes. We cover the cage with a cloth every night.
Action step P: Did this then too.
Cognition P: Because when he sits in the dark in the morning, he also keeps still.
Cognition P: That's why I've been able to put food in his cage.
Cognition P: I then turned out the light so it would be dark.
Cognition P: The next morning, when it would be light again, he would see the food.
Cognition P: I actually wanted to go down then.
Action step P: I put two bed bottles in the bed.

Joint Action Patient (P), Husband (E): The Last Conversation Before the Suicidal Act

Joint action E-P: Then he called me again at 11 o'clock and asked
Joint action E-P: Whether I could really go to therapy tomorrow.
Action step E-P: He promised that he would then come in the early afternoon for the food.

Suicidal Action Patient (P)

Action step P: Then I went downstairs. I took another glass with me.
Action step P: Shortly after 11 o'clock. I then solved these tablet rolls in turn.
Action step P: I also… I started the sleeping pills.
Cognition P: That was another whole pack.
Cognition P: When we went abroad I bought tablets for sleeping on the plane.
Cognition P: But I have no idea what they're called anymore.
Cognition P: And then a tube of A.
Cognition P: K. I have also solved.
Cognition P: Then I had a packet of painkillers from the trip that I bought there for a middle ear infection.
Action step P: I have also taken these.
Action step P: And then I took my allergy pills.
Cognition P: Just everything I had.
Cognition P: I just felt like because it was about 20 sleeping pills and about 30 more pills of painkillers.
Cognition P: I just felt that with 50….
Cognition P: I just remember having a flash of insight after the sleeping pills and wondering about the meaning of what I was doing.
Cognition P: I thought that now I would have to go upstairs to call 911 to pump my stomach.
Cognition P: But this was just like a flash and then it was over.
Action step P: Then I continued as before.
Cognition P: I remember with this last packet, I was still wondering if I needed to take this one.
Cognition P: Then I still had the feeling that it also needs these, otherwise it might not be enough after all.

Cognition P: Until just everything was there then.
Cognition P: (I have had) No thoughts about it.
Action step P: Am then afterwards….
Cognition P: Yes. And then for me, actually, for a long time there was this moment in the evening to just get into the warm bed and close my eyes.
Cognition P: That was actually always the best moment of the day for me.
Action step P: That was also the case this time.
Action step P: But then I couldn't fall asleep.
Cognition P: Yes. And that's when I found it went longer.
Cognition P: At one point I noticed that my heart was racing.
Cognition P: And at one point I heard the heart pounding in my ears.
Cognition P: From then on, I don't really know anything.
Cognition P: Sunday. I remember that I woke up once at home and I realized that I had vomited.
Cognition P: I just thought, oh shock, you're vomiting on the comforter, so on the blanket.
Cognition P: I can't really remember anything from then on. ◄

Joint Action Patient (P), Husband (E), Doctors (A): After the Suicide Action

Action step E-P: Yes, my husband found me.
Action step E-P: He also came earlier than we agreed.
Action step A-P: … they were going to put the feeding tube in me.
Cognition P: I heard them say that they had tried three times now and that it should really go now.
Cognition P: That this was just very uncomfortable.
Cognition P: The worst part was just the thought that I still had to tell my parents, who had suffered enough as it was, this.
Cognition P: I was so ashamed.
Cognition P: I felt guilty.
Cognition P: I was just ashamed.

Joint Action Patient (P), Husband (E), Doctors (A): Meeting of the Patient with Husband After the Suicide Action

Cognition P: The first positive feeling. When on Monday… My husband wanted to come to me on Sunday, in the evening.
Action step A-E P: But then the doctor in the ICU had said not to come now.
Action step A-E-P: It was not the right time now.
Action step E-P: Then he came on Monday night.
Action step E-P: And in the way he came….
Action step E-P: And how he had shown me that there was still some feeling for me.
Cognition P: I was very comfortable with that.
Cognition P: This remained until today and still motivates me.

Action Patient (P): New View and Look Back

Cognition P: I see it with different eyes now.
Cognition P: I think my husband has also contributed to my illness.
Cognition P: But he's also had a hard time, even a lot.
Cognition P: This I see only now, I have the feeling.
Cognition P: As it had been for him.
Cognition P: I didn't see that before.
Cognition P: I had more anger towards him before.
Cognition P: I thought that he had now got me into the whole mess and that he should also now pull me out of the whole thing.
Cognition P: But today I see that he had also had a very hard time and so did my parents.
Cognition P: They suffered a lot by the fact that I just didn't let them help me, that I just blocked them.
Action P: So I became very withdrawn, didn't pick up the phone.
Action P-E: I actually only had contact with my husband, no one else.
Cognition P: There (at the place of residence) I didn't know anyone.
Cognition P: I don't actually know anyone from A (after) a year and a half.
Cognition P: My mother, I think, suffered the most.
Cognition P: They had simply felt a certain powerlessness.
Cognition P: And I went the way I wanted to go, the way I wished to go, until the end.
Cognition P: That's where I actually already feel like they couldn't do anything there.
Cognition P: I could still do what I thought was right.
Cognition P: Mother had suffered the most, from the feeling of powerlessness, not being able to help and having to watch it happen.
Cognition P: In a village where there is no understanding of a daughter with a crack.
Cognition. P: And on top of all that, the daughter wanted to take her own life.
Cognition P: Even today, they can't tell everyone.

Action Patient (P): Future Plans

Cognition P: And for me it's simply that it just didn't work out and that I now have to stand by it.
Cognition P: Otherwise, I feel like I can never get better.
Cognition P: I have to stand by both, the illness and the suicide attempt.
Cognition P: It always involves tears, but then it does.
Cognition P: "You just have to" I feel.
Cognition P: I have lied and played hide and seek enough now I think.
Cognition P: I just really need to stop doing this now.
Cognition P: The time, the event of my suicide, is a section I would like to cut (out of my life).
Cognition P: Simply a section that may never come again.

Patient (P) Action: Relationship Formation with the Husband. The Positive Effect of the Suicide Attempt

Cognition P: The positive thing is that my husband did have to think about it a little bit, maybe a little more intensely than if he had just moved out.
Cognition P: What feelings are still there for me and whether it is still worthwhile with us.
Cognition P: That was maybe… He just thought about us in a different way, and he still thinks that way.
Cognition P: In contrast, if he had just moved out.

Joint Action Patient (P), Nursing Staff (PP): Treatment of the Patient by the Nursing Staff in the Hospital

Cognition P: With the nursing staff, I feel like they don't like me because of the way I am.
Action step P-PP: When I'm cold, I ask for a bed bottle.
Cognition P: Just little things like that that make their lives harder.
Cognition P: That's just where I feel like some of them judge me because of that.
Cognition P: That can also be….
Cognition P: In the first few days, when I wasn't on medication, I felt like everyone was against me.
Cognition P: Then when I got medication, all this looked very different.
Cognition P: This may also be a mere imagination on my part. ◄

Patient (P) Action: Family Reaction

Cognition P: Family? They are all just enormously relieved that I am here now.
Cognition P: They also support me.
Cognition P: It's probably already me that needs to get better, that this is all going to be okay.
Cognition P: Just all the family life that hasn't happened anymore.

Actions Patient (P), Parent (El): Family Predisposition

Action step P-El: I then also asked the parents to do a little research into our family history.
Cognition P: But there have been no cases of melancholy in either family that they would have known about.
Cognition P: Be that great-grandmother or great-grandfather. It simply has not existed up to the present time. ◄

Summary

1. Mrs. Meier describes several actions in her suicide project. It is first the suicide action and the time afterwards when she was treated in the hospital. She details the suicide procedure in implementing the suicide intention and the suicide action. This begins with the husband withdrawing, informing that he will be moving out. The patient does the household chores as usual, prepares and checks the medication overdose, then wants to secure the bird from starvation after the patient's suicide, makes arrangements for the next morning, has the last conversation before the suicide action with the husband, and takes the overdose.
2. After the suicide action she describes her encounter with her husband, describes her new view and takes a look back, talks about future plans, about the relationship with her husband and about a positive effect of the suicide attempt on their relationship. In addition, she talks about her treatment by the nursing staff in the hospital, about the reaction of her family and about whether there were already such mental problems in the family.

4.2.2 Problems of Action Organization

There are a number of difficulties and dysfunctions in the actions and projects of suicidal persons. The problems of action organization concern first of all the relationship of the levels of action organization to each other in actions and projects, as well as the relationships of actions and projects and long-term concerns. Last but not least, we encounter problems in the relations of projects to each other as well as of long-term concerns to each other. This patient also subordinated her most important concern, staying alive, to other projects and long-term concerns. She thought she could not live without her husband. However, she made living together unbearable for him because of her eating disorder, her eating, vomiting and starving, so that he wanted to separate from her. One way to maintain the marriage and the relationship would be to engage in treatment. However, the patient refused to do this because she felt she could not endure the panicky anxiety she would suffer if she had to give up her routine of eating and vomiting, which was set to the minute. Thus, her desire to "avoid panic anxiety" controlled her "avoidance of eating disorder treatment," which in turn destroyed her "relationship with her husband," upon which she then conditioned her "staying alive." However, not only was the patient's relationship with her husband destroyed, but the patient also "avoided contact with others in the village" and felt she could not visit her family of origin because of her eating and vomiting routine. While this may not seem central to the suicidal action in the patient's narrative, conversations and contacts with acquaintances and relatives could prove helpful in such cases. Similarly, in the relationship with the husband himself, which was so important to the patient, the patient not only showed herself to be recalcitrant in her avoidance of eating disorder treatment, but also described the relationship as thoroughly destructive. She feels that her husband bore his share of her problems and that she was often angry with him. It

seems that this suffering was of great importance to her and that she could not do without him. With the assumption that the patient learned or built up this concern of "forming her relationships in this way" earlier, but about her time before and outside of marriage the patient speaks very little. She only mentions that she could not visit her family of origin because of her eating and vomiting routine and that she was very ashamed of her suicide attempt in front of her mother. Thus, only assumptions can be made about her relationship arrangement in the family of origin, based on eating disorder experiences and investigations, but not on this patient's reports. Another problem in the disorganization of the patient's long-term concerns is evident from her care for her bird, on the one hand, and her indifference, on the other, to her husband's dramatic feelings that he would surely experience after her suicide. The concern for "husband's emotional well-being" seems much less mirrored in her actions than the concern for "taking care of the bird." Of tragic scope was the confusion in the hierarchy of goals during the suicidal action. The thought of calling 911 came up, i.e., the overarching concern of "staying alive" was brought to attention, yet the patient was unable to gain action-guiding strength from this connection and frame this as an important alternative action. She felt it was just a flash of thought that quickly passed.

► **Summary**

1. The problems of Mrs. Meier's order of action can be inferred from several contexts. They are most evident in the hierarchy of goals, in which survival becomes a secondary concern, while her fears of not being able to keep to her routine of eating and vomiting take precedence over everything else.
2. She reveals a further problem of ordering her actions in the way she forms her relationship with her husband, which she forms destructively despite her esteem for him and the importance she attaches to this relationship.
3. Finally, a problem of ordering action is also present in the actual suicide act, in which she can no longer use the option of calling the emergency doctor to guide her actions. In this way, an alternative action that is essential for survival becomes one thought among many.

4.2.3 Consciously Prepared or Spontaneously Undertaken?

Since Mrs. Meier gives a detailed and credible account of her suicidal preparations, her suicidal action can certainly be seen not only as a top-down steered one, like the majority of suicidal actions, but also as an action planned long in advance and developed in a suicide project. It is not only the few days immediately preceding the suicidal action, but also the medication hoarding and preoccupation with death that are part of it. Her fears of giving up her eating, starving, and vomiting rituals narrowed her life options more and more, so that she saw death as the only way out.

▶ **Summary**

1. The patient prepared her suicidal action over a long period and carefully, although her husband's decision to leave her determined when she then took the overdose.

4.2.4 Problems of the Action Monitoring Processes

Conscious attention, emotions and pain are the most important processes of action and self-monitoring in acting. In this patient, what stands out is the discrepancy between how life-determining her panic about giving up her eating and vomiting routine was and with what composure and orderliness she engaged in her suicidal action. She did relate that she felt her heart racing after the overdose, though we do not know whether this was emotionally or narcotically induced, and that she was unable to fall asleep. However, an inner calmness was mirrored to her at the same time, which could indicate her contradictory self-experience. This also confirms her realization that she makes in the self-confrontation by noticing that she did not see herself as the person suffering from eating disorder, but only had the empty apartment in front of her. In her suicidal action, however, she did not turn off her emotionality on the one hand, because she was looking forward to going to bed (her favorite moment of the day) and when she saw that she soiled the bedspread by vomiting, she was quite upset. On the other hand, in the self-confrontation interview, she tells how at the moment of overdose she was animated by her determination and felt no emotion. She also cared heartily for her bird and one could assume that this was definitely well-felt emotionally. In order to ensure the timely feeding of the bird, she thought of a relatively complex organization of action. In order to get her husband home early, she lied to him with the story that she was entering treatment. In addition, she covered the bird cage so that the bird would not start looking for food. The patient also mirrored the details around her overdose very accurately, indicating a decent momentary attention function. What was not successful, however, was monitoring the hierarchy of goals and revising the alternative actions taken in light of the important concerns.

▶ **Summary**

1. During the suicidal action and the preparations for it, the patient observed her surroundings and herself very attentively. She was also present with her feelings when she experienced joy when going to bed, took care of her bird or was worried that the bedspread would not be damaged. She was also physically aware of herself and noticed her heart racing, although she spoke of an inner calm.
2. But what she completely blanked out was the inappropriateness of her action to solve her health problems. The importance of her life and the concern to "stay alive" completely disappeared from her attention.

4.2.5 Problems of Action Energization

Emotion as action energizing initially dominated the patient's actions in a negative way, as avoidance. The patient reported panic fears of giving up her eating and vomiting routine. What actions she energized with her anger toward her husband we can only guess. She talks about the positive emotions that were actionable when she talks about her care for her bird, perhaps her housekeeping, but most of all her going to bed, the best moment of the day. Not consciously experiencing and shaping the day, but shutting out that consciousness through sleep was what she looked forward to most each day. When the patient woke up in the hospital after her suicide attempt, she felt very ashamed at the idea that she would have to look her mother in the eye after this action. We can imagine that shame was an emotion that energized her actions for a long time. While the panic fear of giving up her eating and vomiting routine was action-dominant and destroyed her vital relationship and thereby energized, albeit indirectly, the suicidal action, ev. fears of dying – patient reports several times that she had too little courage to bring about her death sooner than the desired death by heart failure failed to materialize – showed up as not action-dominant and ev. only noticeable in physical symptoms, such as palpitations and problems falling asleep.

► **Summary**

1. Mrs. Meier makes us understand how she mainly energizes avoidance actions. The fear of giving up the eating, starving and vomiting routine makes her "move mountains", lie to her beloved husband and above all want to die.

4.2.6 Suicide and Interactive and Joint Action

The patient describes in no uncertain terms that she had a clear idea that she wanted to die or commit suicide and under what conditions she put this intention into practice. From the "I cannot live without my husband" one can understand the interactive meaning of this joint action of suicide, even if the husband did not know about it. However, in the patient's narrative there are further clues to how these partners shaped their joint projects and actions and the communication in this joint action, the thinking of the couple. Lying to the husband that the patient was entering the clinic so that he would feed the bird after her demise caused her no trouble. The husband, on the other hand, lied to her that he still had to go to the office while preparing his departure from the apartment they shared. He did not dare to tell her this, but also had to communicate this message in writing in increments, because he did not dare to write the whole truth. Finally, the patient expresses satisfaction when she wakes up after her suicide attempt that her husband must now realize he has to face her problems instead of running away. All these actions of communication point to a massive problem in the shaping and organization of the joint actions of the partners as well as the patient.

The character of the joint actions in the patient's suicide project is not only evident from the fact that the patient tries to kill herself after her husband leaves her, but also that her husband is also the first person she meets again, apart from the treatment staff in the hospital. Of further importance is how fastidious the patient is in keeping all other persons out of her common projects and suicidal concern. She did not make any acquaintances in her new place of residence, as if she did not want to be distracted from her main concern. It is obvious that any psychotherapeutic treatment of this patient would also take into account her social actions.

▶ **Summary**

1. Although Mrs. Meier presents herself as very withdrawn and does not maintain any acquaintances at the place of residence, she makes her suicide attempt dependent on her husband breaking off the relationship. The husband is also the last person she meets before and the first person she meets after the suicide attempt.
2. Even though this relationship is so suicide relevant, it is still maintained in a complicated and destructive way. They cannot address many things openly, both resort to lies, and finally the patient welcomes her suicide attempt as a means of getting her husband to confront her problems.

4.2.7 Mrs. Meier's Conversation with a Psychiatrist

In the **1st joint action** the doctor formulates the task, which he presents as a question, that the patient should tell him how this event occurred. She describes it briefly and succinctly. She had been carrying the desire around with her for a long time:, "but it took a drop to make the barrel overflow." "Due to my illness, one day my husband could no longer go on. He was also stuck in this vicious circle in his own way, so one day he wanted to move out. That had been the deciding factor for me. I can't imagine my life without him." In the **2nd joint action,** which was devoted to the weekend in question, the patient describes the events that preceded the actual suicidal action. The psychiatrist kept asking for clarifications and confirmations of how he understood what was said, and in each case wanted to know the time when the described action steps happened.

In the **3rd joint action**, the patient reports the moment when she lay down in bed and took the medication overdose. She was able to clarify in this action where the medication came from, how the couple's relationship dynamic played out, which the patient described as a vicious circle. She could not imagine life without her husband, but could never bring herself to contribute to making the relationship better by going to the clinic.

How the patient woke up, first at home and then in the clinic, when they wanted to insert a feeding tube, she describes in the **4th joint action** of the conversation. The doctor asked her about her feelings and the patient dealt with this issue. She mentions feelings of shame and cares mostly about the feelings of others, her mother and husband. However, she can also look back with different eyes. The doctor introduces the **5th joint action** with

a question so that the patient also wants to look at herself and how she suffered. The patient takes this retrospective as an invitation to face up to herself, her problems and to stop lying and playing hide and seek. However, she cannot take her suggested change of perspective as a positive thing that her suicide led to, but thinks that her husband, in particular, should now be more concerned. In the **6th, final joint action,** the patient thinks that not being liked by the hospital staff because of her nature is the only negative experience she has to report. When the doctor comes back to her family and also wants to know whether the patient has a family history, the patient says that her research into this has been negative. They say goodbye.

The doctor structures the conversation to a large extent, even if he lets the patient talk freely. When describing the suicidal action, he tries to record the exact sequence of events and, above all, the timing of the individual action steps. After the patient described the final suicidal step, he wanted to know what thoughts she had. As the patient related her stories with the hospital treatment, the doctor clarified the individual circumstances and details of the events (where, who, when, etc.) by asking questions. From the patient's narrative, the doctor picks up on a concept "vicious circle" that the patient was using and asks her to clarify this. Regarding the suicidal intention, the doctor wanted to distinguish between "just having peace of mind" and "putting an end to existence". The doctor also clarifies the next topic "wanting to die by starvation" by asking questions (who, where, what, when, why, etc.). When the patient reports her emotional state, he suggests some feelings and behaviors that could have applied to the patient. Inquiring about how she felt when she woke up, the doctor doubles down on whether the patient still felt ashamed, to which the patient responded in the affirmative, and from this feeling she then describes her view of her relationship and the next task in life. The doctor is then confronted with the patient's difficult relationship formation, which he then wants to clarify. The patient also sees her current stay in hospital as shaped by the same relationship strategy.

▶ **Summary**

1. In the first joint action, the task of the conversation is defined and the patient explains her suicidal action, to which she then describes the preceding weekend in the second joint action. She describes the moment of taking the overdose in the third joint action.
2. The fourth joint action is devoted to the time of waking up in the hospital and the patient's thoughts and feelings at that moment. However, since these only apply to the others, in the fifth joint action the psychiatrist encourages her to think about herself. Mrs. Meier, however, derives from this event an obligation for her husband to change his behaviour towards her.
3. In the final joint action, the patient tells of her feelings of not being liked by the hospital's nursing staff.

4.2.8 The Self-Confrontation Interview

In the **1st section** of the self-confrontation, the patient says that in talking to the doctor it was as if "…just this day was playing out like a movie in front of my eyes again." She was focused and found the doctor to be listening attentively.

In the **2nd section** the patient reports the despair she talked about when she read the news of her husband. In addition, she again felt the almost unbearable uncertainty because she did not know when her husband would return.

In the **3rd section** of the self-confrontation, with the conversation in which she reported on the time when she was concerned about how the bird would be fed after her death, the patient provides further insight into her thoughts. She says it was important to her "…that I had some assurance that ultimately this poor innocent animal would not have to suffer." This suggests how guilty she thinks other people around her are because they should certainly suffer appropriately after the patient's death, as she made no arrangements in this regard. This was not a spontaneous thought but it was a long term concern because she also reported how at another time she made further arrangements "…when my husband was on military service, (I had) had an agreement with my mother that she would just ring my bell twice in the morning and I would do the same. Just that I had an assurance that if something happened with my illness, that if I had had a cardiac arrest, someone would notice and look to the animal."

The moment when the patient went downstairs to the bedroom with the filled up water glass and many sleeping pills is described by the patient in the self-confrontation **(fourth section)** as a moment of determination. She felt that after she solved the main problem, taking care of the bird, there was only this determination and no more feelings. In the interview, she felt positive feelings towards the doctor, as she described him as very empathetic and very interested "…in me being able to open the button." In the **5th section** of the self-confrontation, when she looked at the part of the interview where she reported how she was lying in bed waiting to die, the patient described the inner peace she felt at that time. However, she reported that she also had the racing heart she felt during the suicide action she also felt at the time in the interview and also at home, each Saturday (it has been 14 days since her suicide attempt). In the **6th section** she states again clearly and more clearly than in the interview that she really saw no future at that time and was determined to end her existence and not simply experience a little peace. She describes her determination in the action of suicide as "…a kind of cold-blooded." The great impact of self-confrontation was evident in the **7th section** when the patient looked at the part of the interview where she talked about the cancelled clinic appointments that her husband made for her. "…I'm only now seeing that towards the end he didn't have a home either, that it had been almost unbearable for him as well." "It just tortures me too. Because before that, I had only seen myself at home." The part of the conversation in which she talked about her wish to be buried in the community of origin is discussed by the patient in the **8th section** of the self-confrontation. She says that talking about her funeral moves her a great deal, while when it comes to her suicidal action, she remains numb or calm. She attributes this to the

fact that her parents were also affected at the funeral, which moved her. However, we can surmise that the grief at the funeral is a shared grief, whereas the feelings of the individual when they commit suicide is a personal experience. Since we know that the patient has trouble experiencing the feelings that affect herself, but can certainly share common joint feelings, we can understand this discrepancy. In the **9th section,** the patient tells us about strong feelings in the interview when she talked about her fatigue, as she was very weakened by the eating disorder and could hardly do her household chores. In the **10th section** of the self-confrontation, the patient talks about an experience she noticed during the self-confrontation. When she talked about her eating and vomiting routine during the interview, she did not see herself, only the empty apartment, which she now notices when viewing the scenes. "I saw, amazingly, at that point, not me eating and vomiting, but part of our apartment; just the one window that leads out onto the balcony. I always saw that one in front of me." "Actually, never at all the situation where I'm standing in front of the toilet crying like a castle dog and wondering why I keep doing this. But I kept doing it over and over again. I didn't see this scene then. I am only seeing this again now." This statement also points to Mrs. Meier's self-monitoring problems and also to the potential constructive effect of the self-confrontation experience.

In the **11th section** of the self-confrontation the patient reports her bad conscience because she behaved too harshly and unkindly towards her bird and saw his disappointment in his eyes. She says that this was a strong emotional concern for her then and also now in the moment of self-confrontation. The part of the conversation when the patient woke up in the ICU was looked at by the patient in the **12th section.** She simply saw her surroundings in the ward and would have preferred to close her eyes again. In the **13th section,** the patient also tells of a change that she is only now experiencing in this self-confrontation interview "I didn't feel at the time that it was also hard for my husband, that he also just didn't have a home anymore, that it must be almost unbearable for him. I didn't see that until today." In the **14th section** of the self-confrontation, the patient describes a certain disappointment that she had woken up and was alive. She thought "… that I simply did not want this, and that now everything would be even more difficult. On the contrary, I just wanted this all to stop, that everything just had an end point for once." She still speaks of seeing her father in the hospital, and she awaited this encounter with dread. She wished to see him but didn't know how he would react, but "It was actually at that moment as I expected, because he's bad at showing his feelings." In the **15th section,** the patient tells of some fatigue and thinks that she is losing her train of thought. However, she emphasizes that "Yesterday… Since I can say that now I want to tackle this second chance and get better I feel better." In the **16th section,** when the patient talks about the part of the conversation in which she described the situation in the hospital, it becomes apparent how little resilience she still has. When things did not go according to plan on the ward because of emergencies, the patient wanted to escape, which only did not happen because she did not have shoes and clothes in her wardrobe. In addition, the patient was told that she had to eat and drink at certain times and that she should always admonish the nursing staff if they did not prepare this. The patient spoke of massive problems getting her way with the

nursing staff. From the encounter with her mother, she talks about the mother's observed relief, because finally her daughter is in the hospital where her problems are taken care of. In the **17th section,** the patient expresses some final thoughts. She suggests that as she recovers physically, she also begins to question everything "Why did it come to this?" The patient comments on the challenge of the self-confrontation interview "I am amazed that I can do it. Also, for example, talking to you now about all this, even though I don't know you at all." "I just feel that this is also a sign of improvement, that everything is looking a bit more positive already. I feel like if I couldn't talk about it, the chances of healing would be less than they are now."

▶ Summary

1. The self-confrontation interview not only opens up access to the patient's thoughts and feelings during the interview and during the actions described, but also creates for us, as in this case, access into her world of thought. When she says that the innocent animal should not suffer as a result of her suicide, we can imagine how the others, her husband, her parents, are guilty in her eyes, because they should probably suffer.
2. It also adds some information about her inner state at the moment of the suicide attempt, which she did not address in the interview with the psychiatrist. Of particular interest is also her split self-perception, because she described an inner calm with simultaneous heart palpitations. This racing heart has since always occurred on the day of the week of the suicide attempt.
3. There are also already some effects of self-confrontation, because the patient, according to her, only now realizes how difficult their living together was for her husband.
4. In the eighth section, the patient explains how her suicide leaves her cold-blooded, but her funeral, attended by her parents, moves her greatly.
5. The self-confrontation interview also made the patient realize that she never saw herself as the person suffering from her eating disorder, but only saw the empty apartment in front of her. She also feels that when she was able to talk about everything during the interview and the self-confrontation interview, which she was not able to do before, that this was a sign of improvement.

Case 3

5

5.1 Suicide Story: Ms. Widmer, Who Nobody Listens to

Kornelia Helfmann
Berne, Switzerland

Ms. Widmer sits on the bed in her room and talks to her sister on the phone. They're discussing the furnishings in her bedroom, which she finds sterile and has long wanted to make more comfortable, but she doesn't know how, she simply has no flair for it. There's a big bed, an old-fashioned lamp from the thrift store above it, nightstands left and right, and a closet. That's it. Matthias, her partner, doesn't care that much; she'd even say he doesn't care at all. They don't have that much money for new purchases anyway. She works as a saleswoman in the food department of a large department store in the centre of town, Matthias as a car mechanic.

Matthias, with whom she has lived for almost 2 years, is in the kitchen; today it is his turn to cook. She hears the doorbell and shortly afterwards the cheerful voice of Susanne, a mutual acquaintance and friend of her cousin Rolf. Ms. Widmer's alarm bells start ringing. She has suspected for some time that Susanne is making a pass at Matthias.

Her sister says she should hang up some pictures and finally buy some curtains, that she could have done that a long time ago. Ms. Widmer takes this as a reproach. She actually wanted to tell her sister that she hasn't been feeling well all day today, that she came home from work exhausted and sad. But she knows that her sister is not receptive to this.

You also need to repaint the walls, her sister says, maybe a warm yellow. She doesn't like yellow, her sister should know that.

Ms. Widmer thanks her sister for the good tips and hangs up the phone. The pair in the kitchen are talking loudly, laughing uproariously. Her hands start to shake. She feels so out

L. Valach, A. Reissfelder, *Casebook Suicide and Suicide Prevention*,
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of place, so completely worthless. She should get up now, she thinks, and tell Susanne to leave Matthias alone, but she can't manage that. They wouldn't listen to her anyway; no one has ever listened to her. When she hears the loud laughter in the kitchen, a film starts playing in her head:

She is in the ninth grade, trying to tell her friends during the long break that she is hurt by the fact that her parents favour her little brother. Since he arrived, a son, finally, after three daughters, a latecomer, she is worth even less than before. Her mother adores her little prince; her father doesn't bother with her at all. Her friends don't listen to her, they have other worries: first crushes, jealousy, contraception and such; they don't care about worries over a little brother. They laugh at her. Forget it! She feels like she's from another planet, like she doesn't belong. She thinks about what it would be like to jump off a high building. To just be gone. But she can't tell her friends that. Now they talk about makeup and fashion. She'll never tell them what's on her mind again.

That loud laughter in the kitchen again. Matthias seems to enjoy it. And Susanne has been visiting conspicuously often lately, mostly when she can be sure that Ms. Widmer is at work. She's certainly been doing more of that. Matthias hasn't laughed so much with her in a long time.

What does Susanne have that she doesn't? She has to get out of here now before she goes crazy.

Ms. Widmer gets up and goes down the stairs to the laundry room. Clears out the washing machine, hangs up the laundry. Just to distract herself. But that's when the next film starts:

She is sitting at the kitchen table with her parents, her little brother and the older sister, who moved out some time ago and now, on Sunday, has come for lunch. The father proudly praises his son's school achievements; he has never praised her, although she always gets very good grades. The mother shows everyone her prince's latest report card. Maths good, English good, Biology good…. The fact that she has always done very well in these subjects doesn't seem worth mentioning. Fierce jealousy spreads, her food gets stuck in her throat, she pushes the plate away. No one notices. No one asks if she doesn't have an appetite, if she's not feeling well. She wanted to tell them today that she wasn't doing well in training, that the boss was picking on her and that her colleagues had absolutely no team spirit, but as soon as she opens her mouth, the others just carry on chattering. So she swallows it all. They'd tell her she's too sensitive anyway, that she takes everything personally. It's a gift. She'll go on sick leave because she can't take it anymore, then the father will react with incomprehension, blame her. Don't be like that, he'll say. At least he'll react, even if not in the way she'd hoped.

Ms. Widmer hangs up the last pieces of laundry and goes back upstairs to the apartment. Her cousin, Susanne's boyfriend, is also there now. Well, actually, sometimes he's her boyfriend, sometimes not. The two of them always fight when they're around. Bad words fly back and forth, they yell at each other. It's like that again. Why do these two come to her apartment to fight? She's never been able to stand fighting. It's unbearable. She stands in the kitchen doorway, no one taking any notice of her. Whether she's there or not, it doesn't matter. Her boyfriend ignores her. He always acts like that when her

cousin's around. Talks big, acts macho. She's already called him on it, but he thought she was blowing it out of proportion and didn't want to talk about it. In general, it's hard to talk to him about what's bothering her. He knows she's already thought about suicide, but she doesn't get the impression that he's really taken her seriously. Actually they only talk about trivial things, who's going shopping today, who's cooking, who's doing the laundry, it's been going on for quite some time. It looks like they've slowly but surely grown apart, like an old married couple, yet they're still so young. She's 22, he's 3 years older. Is that it? What's the point of their lives anymore? She's superfluous and always has been. Never had the place in life she wanted. Never had the friends she wanted. She's not interesting. Everything works without her.

Ms. Widmer goes into the bathroom and looks at herself in the mirror. A narrow face, rather pale. Beautiful large, dark eyes. Long blonde hair, tied in an old-fashioned knot at the back of her head, as always. Full lips. Sad tug around the mouth. Pretty, she was, her boyfriend had said when they'd first met. When was the last time he'd said that? She can't remember. If only Susanne would stop laughing like that. If only her boyfriend would stop flirting with her. Susanne is only half as pretty as she is, but she is so lively, and apparently Matthias likes that. And Ms. Widmer is so often sad. Depressed. He can't deal with that. It bugs him. What if he's into Susanne? Or is there already something going on between them and she hasn't noticed? She was cheated on by a boyfriend once before; she came close then to jumping off a high building. But back then, just out of college, she had a temporary job at another department store, with a good team, and a kind boss who listened to her. Not that Ms. Widmer told her about her thoughts of suicide, but she did confide in her about her then boyfriend's cheating. She was comforted, taken under her wing. She even got to stay with the boss for 2 weeks until she could move into her first apartment of her own. She was doing quite well there, because she only had arguments with her parents to deal with. Unfortunately, her contract there was not renewed when it expired. At her current job she again has a boss who is not interested in her employees, who wants to do her job and be left in peace, and her work colleagues are all egoists, no team spirit. And the customers also just come, stressed, into the store, do their shopping, run home. No one has a kind word for her. By the time she has to leave for work in the morning, she's already miserable. She should finally look for another job.

Still no one seems to miss her in the kitchen. Everything works without her. She feels left out, a feeling she knows very well. The others are having a good time, and she's on the outside, not part of it. That hurts.

Ms. Widmer opens the mirrored cupboard where they keep their medicines and starts to tidy it up, just do something. At some point the visitor will finally leave, and she will have dinner with Matthias. Perhaps she will tell him how she wants to beautify the bedroom, buy pictures and curtains, paint the walls. Pink, perhaps? They'll probably keep quiet, though, as they have so often lately.

The ointments to the right, plasters to the left, cold medicine in the middle. Where do we put the painkillers? She hears their loud breathing, Susanne's laugh. There's the painkiller she takes whenever she has back pain, which is often. Standing all day, bending over, putting groceries away, it goes to her back. She's been off sick a few times because of it.

Her boss has already told her that she can't go on like this, that she can't stay at home every time she has a little back pain. If everyone did that, he says, they would have to close down the shop.

The medicine lies lightly in her hand. She pulls the instruction leaflet out of the package. A dose of 2400 mg daily should not be exceeded. This corresponds to three to four tablets per day. There are 20 tablets in the pack. There are three packs. She does the math. She's always been good at math. No, very good. Even if her father ignored it.

For example, she reads, an overdose could result in heart failure. That's what it would be. She takes the first tablet out of the aluminum foil and swallows it, then the second, the third, the fourth…. In between she has to drink water so that the tablets don't get stuck in her throat.

In her eagerness, she doesn't hear her boyfriend come into the bathroom. He snatches the now almost empty third pack from her hand and yells angrily at her. What are you doing? Are you out of your mind? He grabs her roughly by the arm, drags her out of the bathroom, says horrible things to her. Why didn't you lock the door? Why didn't you take a knife?

She would have expected more understanding from him. On the drive to the nearest hospital, in his car, she thinks: next time I'll do it so he won't notice.

5.2 Suicide Analysis: Ms. Widmer: I Simply Asked Myself About the Meaning of My Life

Ladislav Valach

The young woman who took an overdose of pills a week ago answers the psychiatrist's question "How did it happen?" and talks about her suicidal action. But she also describes very impressively the feeling out of which she acted, namely feeling out of place and superfluous when she noticed that her partner was talking cheerfully with her cousin's girlfriend, while the patient had already been feeling sad all day. She later states that the feeling of "not belonging" had been recurring since her childhood and was very depressing, to the extent that the patient already doubted the meaning of her life several times.

So she links the suicidal episode closely to some medium- and long-term concerns from her childhood and her school and work years. She thinks "there is still a very long back story" to her suicidal action.

5.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

5.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

"Feeling like she belongs" is an important long-term concern of the young woman that has been repeatedly violated. She reports similar concerns about "feeling understood", "getting attention through special achievements", "being heard by others", "feeling treated as an equal", "being noticed", "receiving recognition". In addition, she sought "support even in bad times" and "faithfulness in relationships" from her friends and acquaintances. She

strove for "harmony in relationships and encounters" and was very unhappy when others argued with her. She presumably also wanted to "appear content and competent" to her parents, as she shied away from conversations with them about her own difficulties, also in order "not to complain".

5.2.1.2 Long-Term Concerns

From the conversation about her suicidal act it emerges that she was repeatedly unable to realize a very important long-term concern "to see a meaning in life", which led to her life crisis. The patient perceived the meaning of life in the feeling of "belonging" and feeling "right in place", or not feeling "out of place". She experienced this immediately before the suicidal act ("In the evening an acquaintance came to visit with her cousin. These two always have huge arguments. I almost can't stand that… I just felt out of place at that moment…") She experienced this feeling repeatedly before. She talked about her problems with her father, who did not pay attention to her: "He is just a person who is so indifferent to everything. When you tell him something, you just feel like you might as well have just not told him… He just never talked to me." Her mother also devoted most of her attention to her brother: "My brother… was just always idolized by my mother. I was jealous of him my whole childhood… The jealousy of him almost consumed me… I just always felt like he was favored." She also found her friendships too unsustainable and often felt left alone: "I had had friends before. But they're always so far away. They like to laugh with me. But when one person is not well, suddenly they are gone." Moreover, they were not always the friends she wanted to have, which contributed to the feeling of being excluded, of not belonging anywhere: "…I didn't belong to the cliques I wanted to belong to… I already had some friends at school. But those I didn't like that much. But the ones I did particularly like didn't want to know about me." This is a feeling "I've had forever." Because of these experiences, she said, "having someone to listen to her" is the most important thing in her life.

Later, too, she experienced her partnership relationships as not binding enough: "For example, I was cheated on by a boyfriend with another woman." At home the situation did not improve and her relationship with her parents did not become easier: "…At that time I had a big dispute with my parents. I can't stand that at all. It's just something that offends me a lot. I just get very sad then and feel worthless."

During her apprenticeship and professional life, Ms. Widmer experienced this feeling of "not belonging" again and again and was very unhappy: "I also did an apprenticeship for two years. I certainly suffered there for two years because I didn't like it that much." At the time of the suicide action, she had a job in which she was equally unhappy: "I just don't like that job. I'm unhappy when I have to go to work in the morning… I don't get on well with people and I don't get on well with supervisors either."

All these problems and feelings occupied Ms. Widmer very much and she would have liked to discuss them, but that was not possible, because: "I simply always had inhibitions about talking to my parents about what frightened me, what was bothering me. I would have needed someone already". Since these conversations did not take place, the patient often considered the ultimate solution - suicide - and finally resorted to it: "But I've often

thought about how I would do it (suicide)… I kept thinking about jumping down at some point… That was especially the case when I was in ninth grade and in apprenticeship. I would often sit down in the evenings back then and think about what it would be like to just break up with everything for once. Those problems and "not feeling understood" at home was just too much for me."

Medium-Term Concerns "Projects"

This basic concern of Ms. Widmer was challenged and endeavored again and again in medium-term projects. Be it friendships at school, first partnership relationships, in teaching or at work. At the time of the suicide attempt, she had been engaged in several short-term concerns or projects. It was initially the "partnership relationship with her boyfriend". She found this relationship threatened because the cousin's girlfriend was showing too much interest in her partner. She wanted to "keep the woman away from her partner." Part of Ms. Widmer's long-term concern to find herself in an adequate job professionally is being sought in her 'current job', but with little success. She feels unhappy there, for various reasons. She bases her feelings on some of the values of professional ethics and interpersonal relationships that are not upheld there: "These people who shop there are always stressed. They always want to be the first at the checkout. "They are indifferent to the other people. It's no different among the clerks either. The best one is the one who is most likely to be out of the store in the evening. I just have trouble with that."

▶ **Summary**

1. Ms. Widmer links her suicide attempt to some long-term and medium-term concerns. The long-term concerns include, above all, "to see a meaning in life", "to feel right in place", "to feel like I belong", "to feel understood", "to have someone who listens to her", "to get attention through special achievements", "to be listened to by others", "to feel treated as an equal", "to be noticed by people who are important to me", "to receive recognition", "to receive support even in bad times", "fidelity in relationships", "harmony in relationships and encounters", "not to complain".
2. Among the medium-term concerns are mainly her "partnership relationship with her boyfriend", "keeping the woman (an acquaintance) away from her boyfriend", "present job".

5.2.1.3 Short-Term Actions in the Conflict Project

Short-Term Actions in Suicide Project; Patient (P).

Suicide Action
Feeling P: …that I had not been feeling well all day. I was sad without knowing a reason for it.
Cognition P: I just couldn't have given a reason.
Acquaintance action: Then in the evening an acquaintance came to visit with the cousin.
Cognition P: These two always have huge fights.

Emotion P: I almost can't stand it.
Cognition P: There's just permanent tension in the air. That's just insane.
Cognition P: They each come to this apartment and argue with each other all the time, using the worst words.
Feeling P: I just felt out of place at that moment.
Cognition P: I can't justify my feelings either….
Cognition P: But I also still had the feeling that the acquaintance still wanted something from my friend.
Action P: I was on the phone in my room with my sister.
Cognition P: That's when I just heard immense laughter. At that moment the cousin was not there yet (only the partner and the acquaintance).
Action P: So I just retreated a little bit. I went to the laundry room to still take care of the work there.
Cognition P: I then had the feeling that everything was better now.
Cognition P: But everything was still the same when I came back up.
Feeling P: I just felt out of place at that moment. I felt left out.
Cognition P: They hadn't even realized I was coming in.
Cognition P: I simply asked myself about the meaning of my life, of my existence. I am simply a pawn in a game. But you can also play the game without this piece. It was just all in that way.
Action P: Then just followed this knee-jerk reaction.
Cognition P: I probably wouldn't have done all this 5 min later. I just think that now….
Action P: But I just took these pills at that moment.
Action Friend: But before I could take any more, my friend found me. ◄

After the Suicide Action, Friend, Patient (P)

Action Friend, P: My friend then drove me to the hospital.
Action P: At first I didn't want to go because I told myself that I had to - finish what I started.
Cognition P: But then I thought that life can have its beautiful sides. I just often don't see them at all.
Cognition P: I just remembered past things.
Cognition P: I just expected help at that moment. I just needed someone to listen to me. It had to be someone who was interested in my problems.
Feeling P: I just had a pretty worthless feeling.
Cognition P: The thought was this… I just didn't see the point of my life anymore. I just didn't see my place anymore. I wondered why I was even alive. I just don't have the place here now that I would like to have.
Cognition P: I think it's a very bad thought when you don't know what to do on this earth anymore. I think that then it's a short reach to pills or to a knife or whatever it is in the specific case.
Cognition P: (I took the tablets). Everything else was just not exactly within reach.

Actions on Suicide Career; Patient (P)

Cognition P: I've never done it before. But I have often thought about how I would do it.
Cognition P: I kept thinking about jumping down at some point.
Cognition P: I'd probably rather jump.
Cognition P: Those were pain pills.
Action P: I didn't stop taking tablets myself. I just took two to three sheets of tablets.

Joint Action Patient (P), Friend (F): Interrupting the Suicide Action

Action F: But then my boyfriend came along.
Action F: He had called me.
Cognition P: I just couldn't hear anything anymore. I was fully fixated on dying. I was just sure of my decision to die… I only had this in my head.
Action F: He then came into the bathroom.
Cognition F: Then he also saw what I had just done.
Cognition P: That (putting an end to my life) was just my firm decision.
Cognition P: He (friend) didn't react very well there.
Action F: He became irascible at that moment. He grabbed me by one hand and pulled me by it.
Cognition P: I still had bruises on my wrist for a long time.
Action F: He just pulled me out of the bathroom and yelled at me.
Action F: He wanted to know why I had done all this.
Cognition P: But he knew the reason perfectly well. He knew from me that I thought a lot about suicide.
Feeling P: So this reaction almost made me sad.
Cognition P: I would have just expected a little understanding from him.
Action P: I told him so much about myself.
Cognition F: He knew what it was like inside me.
Cognition P: I think of suicide as not something sacrilegious. It is simply a solution for someone who can no longer find a way out.
Cognition F: He just didn't understand.
Action F: But he just says that's just my opinion.
Action F: But at that moment he just came up to me and threw bad things at me. He accused me of not locking the door. He just threw things like that at me… Why I didn't lock the door.
Action F: He asked me why I hadn't taken more pills, why I hadn't cut myself.
Cognition P: Because I hadn't brought it about.

Joint Action; Patient (P), Friend (F): Go to the Hospital

Action F/P: He decided to go to the hospital.
Cognition P: I have a feeling that he said all this out of anger. He was not serious about what he said.
Action F: But that reaction… On the way to the hospital,

Cognition P: that reaction just totally fucked me up.
Cognition P: I just thought that if I had the opportunity to do it again in the hospital that I would do it and I would do it in a way that would work. I would have just done it on the spot.

Present
Cognition P: At the moment, I'm actually fine.
Action P: I have also contacted my mother.
Cognition P: I have a good relationship with her. I feel better with her.
Cognition P: I didn't think she could understand that.
Action Mother: But she's trying to help me, she's really trying to understand.

Relationship with the Father
Cognition P: So I want to say with the parents … I had problems. But I had problems especially with the father. He is just a person who is so indifferent to everything.
Cognition P: When you tell him something, you just feel like you could have just as easily not told him. He just always stays the same.
Cognition P: There is still a very long history (to the suicidal action).

History of the Suicidal Action
Cognition P: My brother, he's the youngest of us four kids and the only boy to boot, was just always idolized by my mom.
Cognition P: I was jealous of him all my childhood.
Cognition P: Jealousy of him just almost consumed me.
Cognition P: I was then just alone with my brother at home.
Cognition P: I just always had this feeling that he would be favored. I just had this feeling.
Cognition P/Action father: My father only spoke to him properly. Every now and then he would talk to my mother. But he just never spoke to me.
Cognition P: The mother simply had great joy when the son had the same interests as she had. He was then simply the best in each case. Also in school… With him a grade five (good) was simply worth more than with me a grade six (very good).
Cognition P: I was just very jealous of him.
Cognition P: It came mostly from the father. With the mother, it wasn't so kinky. She was just the way mothers are with sons. I've heard that a few times.
Cognition P: I've just always had inhibitions about talking to my parents about what's scaring me, what's bothering me.
Cognition P: I would have needed someone by now.
Cognition P: But I had a sister and a good colleague to talk to. But that just wasn't the same as once being able to tell the parents what was going on.
Cognition P: I also did an apprenticeship for 2 years. I certainly suffered there for 2 years because I didn't like it that much.
Cognition P: But my parents didn't know anything about it,

Action P: One morning I said I was sick and I wasn't going. I simply had the work certificate and diploma at that moment. At that moment I then said that I could not go on working.
Cognition P: I can't say I didn't have a good childhood.
Cognition P: I am simply a person who is quickly sad and then in each case does not find himself straight again. I can't find anything beautiful then and therefore can't enjoy anything.
Cognition P: I don't feel like anyone was bad with me. But that was just my problem in my childhood.
Cognition P: I am particularly vulnerable.
Cognition P: It was just that nobody ever noticed anything. They already saw that something was there, but everyone didn't think it was so bad.
Cognition P: I notice things like that very extremely, I think.

Actions of Suicide Career

Cognition P: This (thought of suicide several times before) was especially the case in ninth grade and apprenticeship.
Cognition P: At that time I often sat down in the evening and thought about what it would be like to just break up with everything once.
Cognition P: These problems and "not feeling understood" at home was just too much for me.
Cognition P: I had had colleagues before. But these are always so far away. They like to laugh with me. But when a person is not well, then suddenly they are gone. I've often had that feeling too.
Cognition P: Then on top of that, there are friendships with girlfriends and boyfriends. I was very often disappointed there.
Cognition P: For example, I was cheated on by a friend with another woman. That really hurt me a lot at that moment. At that time I was also very close to saying why I still wanted to live. I just wondered what she could offer more than I could.

Actions in the Project: Work in a Department Store

Cognition P: There was then a phase in which I forgot all these problems.
Project P: I worked in a department store for 5 months at that time.
Cognition P: I liked it very much at this workplace.
Cognition P: I had a boss who went to great lengths to understand and comprehend people.
Actions boss: She talked to the employees.
Joint actions boss, employees: And if a person was not well once, then she went with him to drink a coffee, instead of you had to work.
Actions P: I was still living at home at the time.
Cognition P: I was doing very well at that time.
Actions P: I then also lived with her for 2 weeks.
Actions P, parents: Because I had a big dispute with my parents at the time.

Cognition P: I can't stand that at all. That's just something that offends me a lot.
Feeling P: I just get very sad then and feel worthless.
Actions P: Then I didn't have that job anymore. It was a temporary position. I also lost contact with her.
Actions P: I then moved out at home. That was of my own free will.
Cognition P: I would have liked that (place) very much. I really liked it there. It was really very good….
Cognition P: One way or another, they were cutting staff, and of course they didn't want to keep the employees with the fixed-term contracts.
Action P: Then I found work at another department store.
Cognition P: But I really don't feel comfortable there. I just don't feel integrated in a team.
Cognition P: I just don't like this post.
Feeling P: I am unhappy when I have to go to work in the morning.
Cognition P: These people who shop there are always stressed. They always want to be the first at the checkout. They are indifferent to the other people. It's no different among the clerks. The best one is the one who is most likely to be the first to leave the store in the evening.
Cognition P: I just have trouble with that.
Cognition P: I don't get along well with people and also with supervisors.
Cognition P: I've been working there for 4 months.

Suicide Action

Cognition P: True, it was a Sunday. But often all this hits me on the soul.
Action P: When you come home on Saturday, you are always dead tired. You then go home and take a shower.
Feeling P: But you can't really enjoy anything anymore. You don't feel like starting anything. Everything is too much for you.
Feeling P: Then came the feeling of being excluded, of not belonging to anything.
Cognition P: I have always had that (feeling).
Cognition P: I've had that feeling in school too. I already had the feeling that I belonged. But I didn't belong to the ones I wanted to belong to. That was actually the problem at school. I already had some friends at school. But those I didn't like that much. But the ones I did like didn't want to know anything about me.
Cognition P: I just always wanted to make a difference. I wanted to be either with those who were particularly good at school, or with those who were particularly stupid. I just wanted to show something, be something.
Feeling P: I don't feel comfortable with these (acquaintances and cousin) at all.
Cognition P: I got along very well with her. But lately I just have a bad feeling.
Cognition P: I now live with the boyfriend.
Action acquaintance: But she's been over to my house a lot lately.
Cognition P: I just always feel like she's waiting for the moments when I'm not home. She just wants to go to my boyfriend.

Cognition P: This was starting to bother me. I just wonder with time what all this is about.
Cognition P: That was the one that hit me the hardest.
Action P: I was on the phone….
Action Acquaintance, friend: …and she was with him in the kitchen. There she always laughed out loud.
Feeling P: She awakened in me the feeling that she meant to be alone with him. I just felt cheated at that moment.

Relationship with Boyfriend: Present
Cognition P: We (with boyfriend) get along well. Lately things have been getting better again.
Cognition P: Before, I felt like we were just like living apart. Everything just became a daily routine. There was nothing special in our relationship anymore. We also didn't have long conversations together anymore.
Feeling P: I was just afraid that everything would become a habit, that he would just be there in the evening, and that he would just be there in the morning… That's what I was afraid of.
Cognition P: But that's like gone now. There's a lot more to talk about now.
Cognition P: After this (suicide attempt) happened.

Relationship to the Acquaintance: Present
Action Acquaintance: The acquaintance doesn't come at all anymore. She's like… I don't know what's going on either. She never calls me anymore.
Action P: Every time I call her, her mother picks up and says she's not home.
Cognition P: She probably feels guilty or scared.
Cognition P: I just felt like I still had to give her a phone call because I still had a tape of her. I wanted to give it back to her. I just tried it over and over again.
Cognition P: But it does seem strange to me that when I try five times, she's never home.
Cognition P: This relationship (with acquaintance) should not go any further.
Cognition P: I just want to give her the things that are still hers and ask for my things that she still has back.
Cognition P: But then you should leave this relationship the way it left off. I just don't feel comfortable with her anymore. I also don't feel the need to talk to her or see her anymore.
Cognition P: That (how she played with my friend) annoyed me insanely.
Action P, Friend: I have asked the friend before why she always comes when I am absent.
Action Friend, P: Then he simply answered me that he didn't know either. It was just like that.
Cognition P: She (the acquaintance) always came when I was working. It was just weird. One time she was with me. I still had an hour to work. She had told me that she was already going to my house and would wait for me there. And she was in town by car. It really made me wonder. I told her she could wait here, too.
Cognition P: My boyfriend was home. That was exactly what was bugging me.

Cognition P: It was all bound to go bang at one point. But it should have happened in a different way.
Cognition P: I should have just told her once what I thought of her and what I thought of her behavior. I should have just asked her what this was all about. Why, that she was first my girlfriend, and now suddenly his.
Cognition P: I think right now I would be just strong enough to pull something like that off, to actually say what's going on for once.

Future Therapy Project
Cognition P: I would just be happy for someone to just listen to me. I would be very happy for that.
Cognition P: Because I have the feeling that people only listen as long as they are interested. After that they think about something else and just say yes or no from time to time. It just doesn't engage them at all.
Cognition P: Maybe this person can understand me. Maybe this person can help me with my problems.
Cognition P: Yes. I just want to be able to react differently than I have done now.

Actions to Suicide Career
Cognition P: That was the first time I had really tried it.
Cognition P: On the first of August (a holiday in Switzerland) I had the feeling that all this was not so far away. I just came into all these people who were celebrating.
Emotion P: That's when I just got sad again.
Feeling P: That was just that feeling again like "you're there" but just doesn't belong.
Cognition P: I've already been there with the boyfriend. We were just like alone. We didn't know the other people that were there. But still, sometimes everything seems to me like it would be in a movie, or like I would be sitting in front of the TV watching the movie.

Actions of "Not Belonging"; Experience in the Family
Action P, family: When we all sat together at the table, including the sister, and talked to each other, I never got a word in edgewise.
Feeling P: That always bothered me a lot.
Action P: I used to get up and just leave. ◄

► **Summary**

1. The patient describes her actions in the conflict project and in the suicide project. She lists the sub-actions and action steps in the suicide action, then describes the actions immediately after the suicide action, traces them back and gives information about her suicide career. She then describes the joint actions of her and her boyfriend when he interrupted her suicide action and took her to the hospital.
2. She then comments on her presence, states some actions, and then comes back to actions in the suicide history, in the suicide career, speaks of actions in the relationship with her father and during her work in a department store.

3. She still describes her suicidal action in the context of her relationship with her acquaintance, her current relationship with her partner and comments on her future therapy project.
4. She concludes by recounting other actions from her suicide career and describing family actions that contributed to her feeling of "not belonging."

5.2.2 Problems of Action Organization

Did Ms. Widmer succeed in maintaining the adequate organization of action in her thoughts and actions? Was she able to pursue her actions in terms of her projects and then pursue them in terms of her important "life careers" or concerns? Were her thoughts, sensations, and movements part of her paths of action in terms of her important goals? Hardly. She describes the crucial moments before her suicide when she found her acquaintance in a cheerful conversation with her partner: "…I just felt out of place at that moment. I also still felt like the acquaintance still wanted something from my boyfriend… That's when I just heard immense laughter… So I just retreated a little bit. I went to the laundry room… I then felt that everything was better now. But things were still the same when I came back upstairs. I just felt out of place at that moment. I felt left out. They hadn't even realized I was coming in. I just wondered about the meaning of my life… I'm just a pawn in a game. But you can play the game without that piece. It was just all in that way. Then it was just followed by this knee-jerk reaction… But I just took these pills at that moment."

The patient suspects that her acquaintance is flirting with her partner. The patient reflects this situation with the feeling of being "out of place". She responds to this state of mind by withdrawing (to avoid the feeling) and going to the laundry room. Instead of handling the situation herself, she withdraws and leaves the solution to her problem to others. This is a problem of action organization in that the patient assumes that her personal feeling will find a counterpart in a shared feeling among the three people, so that the others will also want to change this group feeling. However, this is not the case. This is fatal in that she wanted to test whether life would go on without her, which is usually the case. When the patient returned, she not only found the same situation, but the flirting increased to such an extent that the patient found it unbearable. She also widened the scope of her feeling so that she was no longer "out of place" only in the apartment, but in her whole life. Consequently, following her tried and tested strategy of "withdrawing", she would also have to withdraw from her life. This procedure arises from a problem in the organization of action. An action step that has its justification in a short-term action cannot fulfil the same function in a comprehensive, long-term action system, such as that represented by the whole of life. Moreover, this system represents the overarching concern because of which we perform the protective actions.

With this aim of "withdrawing," and with a feeling which related to Ms. Widmer's whole life, she saw pain pills, which she then took. Individual elements located at different levels of action organization coalesced into one action. Thus, perceiving a box of tablets also brought

up a suicide project that had been considered earlier as a possible problem-solving option. A life-relevant action was suggested based on external perception. While this is a transient state ("I probably wouldn't have done all this five minutes later"), it is consistent with behavior in prefrontal cortex problems (if a toothbrush is placed in front of a patient, they will grab it and brush their teeth without needing to). An event at the lowest level of action organization (which contains regulatory processes) dictates an event at the highest level of action organization (which contains action goals). The other elements of suicidal action are also rooted in earlier projects and actions. "Feeling out of place," "feeling left out," "another person is preferred," "withdrawing when I am left out," "life has no meaning," "there is no place for me in life," "to suicide," "to do something destructive," "to receive recognition over extraordinary achievements or extraordinary stupidity," "to show something, to be something."

▶ **Summary**

1. A strategy for solving, or avoiding, undesirable perceptions such as "withdrawing" is applied not only to the spatial environment, but also to life as a whole (withdrawing from life, it works without me). This overgeneralization is a problem of the order of action.
2. The sight of a box of tablets brought out a suicide project that had been considered earlier as a possible option for solving the problem. This is a problem of action organization because a perception at the lowest level of action organization (regulatory processes) suggests a concretization of a goal at the highest level of action organization.

5.2.3 Consciously Prepared or Spontaneously Undertaken?

This patient thinks it is a short-cut action that she would not have done 5 min later. This sounds like a spontaneous, unprepared, short-term action, but this is not quite the case. Ms. Widmer also says that her suicidal action was composed of several long-term processes and occurred as a function of medium- and long-term concerns. As stated above, the patient reports situations going back to her childhood in which she was not perceived as important, in which she felt she was "out of place," to which she reacted by withdrawing, doubting the meaning of life, also considering suicide as an option, and, in addition, desiring to gain the attention of others through extraordinary actions. Thus, around a suicidal action the whole framework was already built when Ms. Widmer acutely found herself in a situation that corresponded to this scheme. In this situation she then saw a large number of pain pills which she took. Thus, by the presence of the last part of a suicidal action, the whole system of action and project was put together. Although in this case one can speak of an action initiated from "bottom-up", it still took place as a goal-directed action. "I was simply sure of my decision to want to die".

▶ **Summary**

1. The patient described her suicidal action as integrated in a series of long-term and medium-term concerns. Moreover, she often dealt with the option "suicide" when she doubted the meaning of life. Thus, she built the suicide action on "stock". This is a "top-down" approach.
2. When she was acutely in a situation that fit this schema, the suicidal action was put together from these two parts by the presence of the drugs (bottom-up).

5.2.4 Problems of the Action Monitoring Processes

The problem of going back to past events, to memories, as described above, is not the utilization of what has been learned, but the replacement of present processes of situation reflection by memories in which their origin in long-term memory remains obscured. This may be immaterial in the case of a thought originating in a memory. But if the feeling of "feeling out of place" acquires the same existential significance in adulthood that it had in childhood, when it severely affected identity formation and self-esteem, then an action-relevant emotional monitoring becomes an existentially threatening challenge on the basis of which life can be questioned.

Before the action step of the suicide action, the taking of the tablets, Ms. Widmer reflects the situation from her emotional memory as life devaluing. During this step, her cognitive monitoring was then also problematic. "…My boyfriend… had been calling me. I just couldn't hear anything anymore. I was fully fixated on dying". The discrepancy between what Ms. Widmer should have been monitoring and what she was actually recording gives rise to the problems of the patient's momentary monitoring of self and action. With this reduced and disrupted monitoring, no life-saving correction of the ongoing action was possible. While the memory of a psychological injury decisively shaped Ms. Widmer's action so that she wanted to die, the anticipation of pain did not play a role. The patient reported suicidal wishes by jumping from a greater height, probably a very painful way of dying. These pain thoughts, however, did not report at all when she engaged in suicidal ideation. Adequate monitoring would result in "I shudder at the horrible thought."

▶ **Summary**

1. The problems of action monitoring in the suicide process are evident in several ways in Ms. Widmer's case. She mirrors a present situation with an emotional reminder rather than emotional monitoring and comes to a diametrically different conclusion "this is a life-threatening situation."
2. Then, when she is about to take an overdose of pills, she no longer reflects her surroundings, nor can she check the consistency of her actions with important goals.
3. Pain expectations play no role in their suicide plans and designs.

5.2.5 Problems of Action Energization

The patient often speaks of her sadness, unwillingness and dissatisfaction, which she associates with withdrawal. This was also the case with the suicidal action; she acted like she had in childhood when nobody talked to her at the family table. She says she also finds suicide justified when someone sees no other option, that is, when the person finds no energy for a life-affirming action. She focuses all her energy into the action of suicide, which she often imagined as a leap from a great height. This is an action that definitely requires a lot of action energy. This is the patient's energizing problem. She withdraws all energy from the life-affirming options and alternatives for action and focuses on the suicide action, which she already described with the limited monitoring of action at this moment.

▶ **Summary**

1. The patient seems to lack a life-affirming energy in her life, as she describes herself as sad, tired, dejected, listless, and depressed.
2. For her suicidal action, however, she reserves a lot of energy in her imaginings and suicidal fantasies.

5.2.6 Suicide and Interactive and Joint Action

In her suicide attempt and circumstances, other people play a crucial role. When the patient came home from work and witnessed an acquaintance whom she suspected of making a pass at her boyfriend, flirting with him and the two of them having a great time talking and laughing while she herself was sad, led her to feel out of place. Her boyfriend found her taking pills, berated her and took her to the hospital. The patient also associates her worst experiences with meeting and sharing actions with others. She did not feel comfortable in her workplace because people acted differently from what she wanted and how she thought it should be done. Her childhood is also closely linked to stressful memories, of her relationship with her parents, especially her father, of her school days where she felt she did not take the place she wanted and was not desired by the friends she liked. Her father evaded any conversation, which hurt her deeply. Her desire to be heard became an existential concern. When she found this at a job, she held the supervisor in high esteem. When she lacks the recognition and attention, the loyalty of fellow human beings, she loses the meaning of life and feels that she has no place in this world.

▶ **Summary**

1. Acting together plays a crucial role in Ms. Widmer's suicide attempt, even though she was alone in the bathroom at the time of the overdose. Prior to the suicidal action, she experienced her acquaintance as a threat to her relationship with her partner; her partner, in turn, seemed to enjoy flirting. The partner then rudely interrupts her suicidal action and takes her to the hospital.

2. The crucial emotion of feeling out of place, which played an important role in her suicide, the patient developed in the parental home, deepened in school, with her former partner and at work.

5.2.7 Ms. Widmer's Conversation with a Psychiatrist

In the **first joint action,** the doctor asks the patient to tell how her suicide attempt came about and thereby defines the task of the conversation. Ms. Widmer tells how she came home, what she experienced, how she took the overdose of pills and was finally taken to the hospital by her boyfriend. When she mentions that on the ride to the hospital it went through her mind that life can have its positive sides, the doctor initiates the **second joint action** and asks Ms. Widmer to tell more about this moment. She describes her heartfelt concern "…to have someone to listen to me," someone who cares about her problems. However, they find out that they misunderstood each other. The doctor meant to understand that there was something beautiful even in the suicide situation, which Ms. Widmer corrects, "I just didn't see the point of my life anymore. I just didn't see my place anymore. I wondered why I was even alive. I simply no longer have the place here that I would like to have".

In the **third joint action,** they discuss how this feeling leads one to resort to suicidal means, which Ms. Widmer justifies by the accessibility of the drugs. The **fourth joint action** develops around the issue of past suicidal thoughts. Ms. Widmer stated that she kept thinking about "…jumping down at some point". In the **fifth joint action**, the psychiatrist directs attention back to the suicidal action and how it was ended by her boyfriend. Ms. Widmer describes the subsequent confrontation with her boyfriend and the trip to the hospital in the **sixth joint action.** When she then mentions that she would have liked to repeat her suicidal action, the psychiatrist asks about it, thus initiating the **seventh joint action.** In this, the patient talks about how she reconnected with her mother and how she used to have problems with her parents, especially her father. When she is asked whether she sees a connection to her suicide attempt, in the **eighth joint action** Ms. Widmer describes how she did not feel noticed at home, was jealous of her brother, did not find any recognition and had inhibitions about talking to her parents about her state of mind. In the **ninth joint action,** the patient describes her experiences in the ninth grade, how she did not feel understood and thought about suicide. Later still, she was cheated on by her boyfriend with another woman, to which she again reacted with such thoughts. However, she also reports a positive experience when she encountered the understanding and open ear of her superiors when she was hired. In the **tenth joint action** she tells about her current job where she feels uncomfortable. There, she says, she repeatedly experiences the oppressive feeling of being excluded. She does not belong to the people she wants to belong to. The psychiatrist then introduces the **11th joint action** by asking whether this feeling also occurs with her boyfriend and her acquaintance who flirted with her boyfriend. The patient tells how the relationships developed, how at the time of the suicide attempt this feeling

reappeared, but how the relationship with her boyfriend had improved after the suicide attempt. In the **12th joint action** they reconstruct the development of the relationships with particular reference to the role of the acquaintance, and Ms. Widmer describes how she would like to deal with her in the future. In the **13th joint action,** the psychiatrist inquires whether the patient wants to go to therapy, to which she replies in the affirmative. "I would be happy for someone to just listen to me… Maybe that person can understand me. Maybe that person can help me with my problems". The psychiatrist introduces the last **joint action,** the **14th,** by asking if: "the patient could imagine making another suicide attempt?". Ms. Widmer replies that even after the suicide attempt, the feeling of not belonging came back. It seemed to her as if she was in front of the television and watching the other people in it. She immediately followed up with a memory of earlier times: "When we all sat together at the table, including the sister, and talked to each other, I never got a word in edgewise. That always upset me. Then I would always get up and just leave."

► **Summary**

1. The patient's conversation with the psychiatrist develops in 14 joint actions. In the first joint action, Ms. Widmer describes her suicide attempt and how she came to the hospital. When she mentions that on the journey it went through her head that there are also beautiful things in life, the psychiatrist misunderstands this, which could be clarified afterwards. In the second action, Ms. Widmer emphasizes her most important concern "to have someone who listens to her".
2. In the third, fourth, fifth, and sixth joint actions, they clarify the details of her suicidal action.
3. In the seventh, eighth, ninth, and tenth joint actions, they elaborate on the patient's background story, her hurt feelings, experiences at home, school, and work.
4. In the 11th, 12th, 13th, and 14th joint actions, they deal with the patient's present relationships with her partner, her acquaintance, and her plans for the future.

5.2.8 The Self-Confrontation Interview

After watching the beginning of the recorded conversation, the research assistant asks the patient how she felt about it. The patient says: "It was a bit uncomfortable for me… I find it much harder to watch now. It's just unfamiliar when you have to talk to someone you don't know about things like that". However, she found the conversation good and enjoyable. In this **first section**, the persistent feelings she felt in the suicide situation had also come up in the conversation with the psychiatrist: "I still feel it is as bad as when it happened". She specifies her feeling in the critical situation at that time. "Every time my cousin is around, then my boyfriend becomes macho. Then he doesn't talk to me anymore. I am just like absent in those moments. I don't even exist anymore". As we know, this is exactly the situation that the patient experienced very often in her life and that she can hardly stand, because she feels existentially threatened in her self-image and identity.

In the **second section** she was nervous during the interview because she was supposed to talk about things "that you normally only think about and certainly don't tell anyone". She confirms that she had kept all this to herself before. Not even her boyfriend knows details. In the **third section** the patient talks about her boyfriend's reaction to her suicide attempt: "It's just bad when you get such a reaction from a person you spend almost day and night with… He never hit me either… But at that moment I was scared. …I just thought that I had really misjudged everything". She also experienced a second strong feeling during the conversation in this section. She was excited: "I kept getting churned up inside as I was telling the story. It just keeps coming back to me when I think about it." At that moment, she said, she experienced the psychiatrist's calmness, which she appreciated at the beginning of the conversation, as "weird": "It just almost felt like he didn't care. I just talked for a long time and almost felt like I was alone".

In the **fourth section,** the patient links her suicide attempt to her relationship with her parents. She very precisely addresses the issue of the social embedding of the suicide, without attributing any blame to her fellow human beings: "I wouldn't have brought the parents into play, on my own. But when you think about it all that way, it could still be true. You can't say they're to blame for everything, but that they certainly contributed something." Asked about the roots of her crises, Ms. Widmer says this began in ninth grade. She describes an ebb and flow in her mood that she doesn't understand, "I have a hard time processing things that I don't understand. I just don't know what to do with it." In ninth grade, she says, she thought about suicide because she was having problems with her parents. She felt pressured by them. In addition, she experienced her parents as indifferent: "If I called them, that was fine, if I didn't call them, that was fine with them." After her suicide attempt, she had a very good conversation with her mother: "That really did a lot of good. I didn't know her at all as I had experienced her at that moment. It just saddens me when it takes an incident like this for parents to see that they have one more daughter."

In the **fifth section,** the patient mentions how she felt during the interview and what made the telling so difficult: "I didn't know how to explain all this to a person who doesn't know me at all. I had to explain it to him in a way that he would understand, but that it would still be bearable for me. I don't want to unpack my whole childhood just like that. That would also have taken far too long." In the **sixth section,** the project assistant inquires about relationships with co-workers and supervisors at her various jobs. At her first job after her apprenticeship she was very satisfied and felt comfortable. This is not the case at her current job: she finds the supervisors inhuman and patronising. She therefore intends to look for a new job.

In the **seventh section,** the patient adds that her boyfriend assured her that he did not share the acquaintance's interest in a relationship, and that the acquaintance did not want to visit them so often anymore. And the cousin has the habit of constantly scolding, which the patient hates very much and can hardly stand.

In the **eighth section,** the patient summarizes the development of her feelings in the interview. She had been very nervous and sad at the beginning, but then felt better and

better, also because she had come to more pleasant experiences. After viewing the video recordings of the conversation, she says she is surprised how much she told during the conversation, it did not seem that way to her at all.

▶ **Summary**

1. The self-confrontation interview provides a range of important information about the content of the conversation with the psychiatrist, as well as information about how the patient felt and what she thought during the conversation.
2. She relates that she experienced the same feelings in the conversation as she had recently during the suicide action. In addition, she also felt very nervous because she told private things that she normally only thinks about but does not communicate.
3. She shares her horror at how her partner reacted to her suicide attempt and that she became afraid of him. She also describes how she perceived her counterpart's behavior. How she first appreciated his calmness, but later perceived it as disinterest.
4. In the fourth section, she describes her experiences at home and is surprised that they could be linked to her suicidal action. She addresses the difficulty of explaining all these connections to a person she does not know in a way that he understands.
5. She adds her experiences at work and especially how her partner feels about the advances of her acquaintances.
6. Then in the last section she summarizes the evolution of her feelings and state of mind in the interview. From nervousness and sadness to a better mood because she also told positive things and finally she also shares her surprise how much she could actually reveal.

Case 4

6

6.1 Suicide Story: Anna, Who Is Disgusted with Herself

Annette Reissfelder

Anna lay on her bed and watched her arm – attentively, yet slightly detached, as if it wasn't hers at all. She remembered the film they had seen the other day in her biology class. In it, a lab technician tugged with tweezers at a fiber on an open arm, making the muscle twitch. The subject's arm was numbed and remained still. She was silent, too. It bored her to deal with herself. Like now, as she watched the stain forming on the sleeve of her sweater where the blood seeped into the fabric. It was getting bigger very slowly. She was tired from her thoughts. It was worst before falling asleep. You became more and more exhausted and couldn't find your way to sleep. In the end, all you wanted was for all the thoughts to finally stop, no matter what.

That feeling was particularly strong again today. Even yesterday she had needed a joint and some pills just to fall asleep at all. That had been the day she realized that she and Beat were no longer together. She took another drag on her joint. The smell always made her a little nauseous. But with the pills and the alcohol, it was bearable. She rarely took that combination – and she knew she had to be careful. She didn't want anything to happen, after all. She also didn't want her mother and sisters to worry about her again. It wasn't like that other time, almost 2 years ago. Back then, she really hadn't known what to do. Now it was different – she was going to finish school, and then they would see what happened next. But right now, she just needed some peace, especially from her thoughts. And that was difficult enough.

She didn't understand herself what she wanted – did she actually want to feel something, or rather did she want to feel nothing at all? Wanting and feeling something seemed

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so exhausting, especially where other people were concerned. Especially men. Beat had actually told her that he had to think about whether he still wanted to be with her. He shouldn't have been surprised then that she had broken up with him! Beat already hadn't been in touch much in the last few weeks. Apparently, he didn't want to bother her because he was so busy at the moment. He hadn't explained why he was always working longer hours, and she hadn't asked. Maybe that was normal when you had a new job – everything was different in a new company, you had to learn it first.

When they had met over a year and a half ago it had been really nice. She had enjoyed having someone who could express the things that were hard for her to say. Lately, though, Beat hadn't been much help, at just the time when she could have used someone she could confide in. She had been so glad to have such an attractive man interested in her; he was already 27 and one could have serious conversations with him, he wasn't at all like the goofy boys her age. He had already finished his studies when they had met and was doing a trainee program. He had his own apartment, too. Then he had less and less time for her because he had to look for a new job. Half a year ago they had been getting along well, they had even wanted to go away for a weekend. Since he had started the new job there was no mention of that anymore. Lately he hadn't really wanted to know how she was doing. He also didn't take her with him when he went out with friends like he used to.

But it didn't matter. She didn't really want Beat back. How sorry she was now that they had ever been physically close. He wasn't her first boyfriend, and she'd always enjoyed being close to him, snuggling up to him – she was quiet in those moments. They didn't need to talk. Lying next to him and smoking was a perfect memory. She didn't really smoke, except sometimes a joint. She saw the physical side in a different light now, some of what they did almost disgusted her in retrospect, although it had seemed normal at the time. She cut her left hand a little deeper. It bled a tiny bit more, almost without hurting. A slight burning sensation, that was all. She lay very still.

She didn't want to spin the thought of Beat out further. She already felt overcome by the familiar disgust again. There had been worse spells in the past, where she would have thrown up by now. It wasn't Beat who disgusted her. She was more disgusted with herself. The disgust had gotten milder as she and Beat had grown closer. She'd still cut herself sometimes in the early days, but she had vomited less than before. Especially less often than right after her suicide attempt 2 years ago, of course.

The last few days had thrown her off balance. She felt ashamed that she couldn't get a handle on it. Just a few days ago, she hadn't exactly been fine, but the tension had been bearable. Only since yesterday, she was falling into a bottomless pit. Nothing made sense, nothing fitted together. Nothing had changed dramatically at all: she went to school as if automatically, came back home, did what everyone expected of her so they wouldn't want to talk to her again. She didn't really take part in anything. Why should she? The girls in her class were so childish and superficial, it was better to keep one's distance.

She felt more comfortable with her mother and sisters, but it wasn't any easier to talk about the things that concerned her. The sisters were too small for serious conversation

anyway. And her mother was always just as worried as she was, especially since the suicide attempt. Lately, she kept looking at her questioningly again. She probably continued to meet with the therapist she had tried to insist on bringing Anna along to, which of course she had refused. That was all she needed – to be in the same room with two people who wanted to force one to talk about one's thoughts and feelings, and who were looking for hidden meanings everywhere… Anna was sure that her mother would have been hurt if she had dropped the facade. What good would that do? It definitely wouldn't help her. Why, she couldn't even talk to her own therapist properly. She figured it was better not to let anyone in on her thoughts.

Why was she always getting angry with herself so quickly? She couldn't really explain it. Beat had reacted very badly once when he'd seen her wrist, back when she'd accidentally cut herself deeper than she'd meant to. He had demanded an explanation from her as to why she cut herself, and she hadn't been able to give one. How could she, when she couldn't explain it to herself? So here she was, thinking about him again. She didn't know exactly how she felt about him right now. He was far away, too far. Maybe she should be hurt that he didn't know if he wanted to be with her. She couldn't even manage that. It was easier to feel nothing. Neither pain nor pleasure – just like now. She could watch herself lie there quietly, cutting a little deeper each time.

It had been so easy at the restaurant earlier. The waitress had hesitated for a moment at first, as if noticing the blood on her long sleeves, but when Anna had coolly returned her gaze and ordered a Coke in a firm voice, the moment had passed. The waitress disappeared, not looking at her wrist when she returned with the Coke. That was good. Anna could do what she wanted as long as she didn't let on. She had enjoyed how well she was in control of the situation. Even later, when the waitress brought the pizza, everything was normal.

That was the advantage over the vomiting – there was always a moment when she had nothing more under control any more, she then needed to find a toilet very quickly. That was very unpleasant, especially in a restaurant. She smiled weakly. And now she lay here looking at her wrist. She cut a little more, in the same spot. It was interesting that it wasn't bleeding that much at all, and that was good. She wanted everything to stay in check, after all. Just the pressure, she wanted that to go away – and it did; she was starting to feel calmer, but also infinitely more tired. She was almost relieved. Calm at last, maybe this was the closure she longed for in this chapter. Waking up and starting over, that would have to be nice. Of course she was going to wake up again, later. Only now, she needed to recover first.

Suddenly her mother came into the room. And it became noisy and hectic again. Although Anna tried to stay calm, her mother insisted that she get up and kept saying that they were going to the hospital. All Anna wanted to do was fall asleep. But her mother would not rest. It was no use arguing with her; she simply wouldn't listen, and got louder and louder. In the end, it was probably easier to give in. If one thought about it, it wasn't that much of a hassle – one could drive right into the emergency room at the hospital, she remembered. Her resistance flagged, and she let her mother take the initiative.

6.2 Suicide Analysis: It Was Mainly Disgust with Myself

Ladislav Valach

"…We are trying to understand what went on in people's minds before they took this step. I want you to tell how it happened…" the psychiatrist asked the young woman. The young woman came to talk to the psychiatrist from the acute care unit of the hospital where her injuries were being treated under suspicion of a suicidal action. She inflicted deep cuts and said that although she had attempted suicide 2 years ago, this time she did not. She accepted death but did not seek it. This young woman, who is still in training, separated from her boyfriend shortly before the suicidal action, which she described as the decisive crisis, and immediately afterwards describes some medium- and long-term processes and concerns that she closely links to her suicidal action.

6.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

6.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

In addition to the recent self-harming action, the young woman indicates a prolonged period of at least 2 years in which suicide was a factor. She also began psychotherapeutic and psychopharmacological treatment. Very early in the interview she mentions that she had a difficult childhood and that the truth from that time scared her.

Despite her young age, the woman's critical action is not only a consequence of the relationship with her boyfriend that ended the day before, but it is to be seen as embedded in a series of long-term and medium-term concerns and processes. "Accepting, liking and loving oneself and one's own actions" is an unfulfilled and repeatedly questioned concern of the young woman. For when disgust with herself and her body breaks through, the patient feels existentially threatened to such an extent that she asks about the meaning of life and wants to end her life. After some attempts of distancing by her boyfriend, the patient broke off her 6-month intensive love relationship.

Long-Term Concerns

The young woman emphasizes that her childhood memories and experiences shape her and weigh heavily on her. She cannot remember any details, but she knows that it was a mess back then. She has to think about it very often, she says, but since important parts are missing from this thought process, it just becomes a mental buzz. This she takes apart a 100 times a day, but never comes to an end. So it becomes a long-term concern that she cannot satisfactorily conclude. She experiences a pressure in her chest that increases to such an extent that she feels she has to explode. But when she cuts herself, she can relieve herself, and her energy dwindles.

Medium-Term Concerns

Much more concrete are the young woman's medium-term concerns about her suicidal action. She had been in an intense romantic relationship with her boyfriend for about 6 months. When he expressed a few days ago that he was not sure whether he wanted to continue the relationship, the patient promptly ended the relationship still on the phone and then cut herself very deeply on her forearm several times the next day. She also mentions cannabis use, indicating an already longstanding habit. In addition, she was taking psychotropic drugs during an emotional crisis, the use of which could be understood from her psychopharmacological treatment. Indirectly, this also includes her psychotherapeutic treatment, which she interrupted because she was feeling better and wanted to start a new life. However, when she experienced the separation crisis, she was on her own. The patient also mentions her educational concern that she was working on with her school attendance. She developed some strategies on how to deal with her tensions. For example, she mentions several times distraction through sports, a concern that she certainly also pursued in the medium term. In addition, the patient reports that she had already attempted suicide 2 years ago, which would have to be assumed to have become a medium-term concern based on the current suicidal action.

► **Summary**

1. The patient identifies the most important long-term concern as "accepting, liking, and loving oneself and one's own actions."
2. However, she feels drawn to the "reconstruction of childhood memories and experiences" as if by compulsion.
3. This creates a "mental buzz," from which a "pressure in the chest" builds up, whereupon she "cuts" herself for relief.
4. Her main medium-term concerns are: "love relationship with her boyfriend," "separation crisis," "education concerns," "school attendance."
5. But also: "using cannabis," "psychopharmacological treatment," "psychotherapeutic treatment," "strategies to deal with their tensions," "distraction through sports" and "suicidal tendencies."

6.2.1.2 Short-Term Actions in the Suicide Project

First Suicide Attempt and Therapy

Actions P (Therapy Project): I have been going to therapy for a long time, for about 2 years now.

Action P: …2 years ago I already attempted suicide once.

Cognition P: So that time it had been a suicide attempt, this time it was not a suicide attempt.

Actions P (psychopharmacology project): So I started therapy, also took medication until last summer.

Therapy Discontinuation

Cognition P: That's when I started to feel better.
Cognition P: This improvement was probably based on the medication.
Cognition P: I then decided to stop everything and start a new life.
Action P: So then I also stopped everything, meaning medication, therapy – just everything.
Cognition P: Then I was also fine until the winter holidays, so in the period between Christmas and New Year.
Cognition P: But then it all came back. I felt bad all over again.
Action P: I couldn't talk to anyone about it.
Cognition P: The problem wasn't that I didn't have anyone to talk to, no, I just can't do it on my own.
Cognition P: … When I did the therapy, we reached a point in the summer where we saw the real problems.
Cognition P: I had a relatively difficult childhood.
Emotion P: That scared me too, just the truth.
Cognition P: (I stopped therapy because) … I just wanted to start a new life.

Relationship Breakdown

Action Boyfriend/P: During this time, my boyfriend also broke up with me.
Cognition P: And that's when everything immediately ended for me.
Cognition P: (My boyfriend broke up with me) A day before (before the suicidal action).
Cognition P: (The friendship lasted) About half a year.
Cognition P: The relationship had been relatively intense.
Action Boyfriend: Then he broke up with me.
Cognition P: From that point on, nothing was going right.
Cognition P: He had been altered for a while, for about 2 weeks already.
Cognition P: I noticed that too, of course.
Action P: I called him once from school.
Joint action P/friend: We talked a bit together.
Joint action boyfriend/P: We then got to talking about our relationship.
Action boyfriend: He told me at the time that he didn't know if he still wanted to maintain the relationship or not.
Action P: Then I answered him directly that I didn't want a boyfriend who had to think about whether he wanted to be with me or not.
Action Friend: He just said that he was working too much, that he didn't want to do all this to me. That was a bit funny from his side.
Action P: (I) practically broke up from the phone.
Feeling P: (I felt) Bad. I've been feeling bad for quite a while.
Cognition P: Then the feeling came up in me that now I was to blame for all this anyway, because I showed him that I was miserable.
Feeling P: All of this still hurts.
Cognition P: That was 2 weeks ago Tuesday

Crisis

Action P: Then on Wednesday everything happened. That day I went to school first thing in the morning. In the afternoon I went home again.

Action P: (In the night) I just kept waking up.

Action P: I've had myself cut before (in the last month), just not as deeply.

Cognition P: (I cut myself) … for myself.

Cognition P: I can't remember exactly my early childhood. It was a big mess.

Cognition P: It's always thoughts just going round and round in circles and never coming to an end.

Emotion P: That always drives me almost crazy.

Cognition P: You just have thoughts. You take them apart a hundred times a day and you question them a hundred million times. But you still never come to an end.

Cognition P: You can't turn all that off either.

Sensation/Feeling P: There is simply a pressure inside me. Something just has to go out, but you don't know what it is. You have the feeling that you're going to explode.

Action P: Then when you cut yourself….

Feeling P: One is relieved. You can explain it like this.

Cognition P: I didn't care about that (that I might hit a vein and that I would bleed to death). I didn't tell myself that I was now cutting here so that I might hit a vein. But if it had happened, I wouldn't have cared at that point.

Crisis Actions

Action P: (After this telephone conversation) … I then went home.

Action P-: Then in the afternoon I didn't go to school at all.

Action P: I then went to bed and slept until the next morning.

Action P: Then in the morning I got up.

Action P: Then I took two tablets.

Action P: Then I went to the train and smoked hashish.

Action P: Then I went to school.

Emotion P: And at some point in school in chemistry class, I had to cry.

Action P: Then I went on to school.

Action P: At noon I went home again on the train.

Action P: Then I smoked hashish again.

Action P: Then I went to bed to sleep.

Action P: Sometime around five o'clock I woke up. The blinds were down. I then turned on the television.

Action P: I took two tablets again.

Suicide Action

Action P: Then I started cutting.

Action P: It wasn't that I just cut myself once. No, I cut myself again and again (in the same place, lengthwise – on both sides) a little bit.

Action P: I just put on a sweater… Then I went out to eat.
Action P: Then I went back to my room.
Action P: There I smoked hashish again.
Action P: I also drank some wine.
Action P: I then went back to cutting.
Cognition P: It bled, not that hard, but still a little. But because I had a tight sweater over it went well so.
Action P: And then I fell asleep once.
Cognition P: I was like in a trance state. I was just out of it.
Cognition P: (The thoughts rushed through the head).
Feeling P: Above all, disgust with oneself. At the same time also hatred of oneself.
Cognition P: At the same time also the questions why me, why all this at all. The question about the meaning of life.
Emotion P: But I already had feelings of disgust before anything else.
Feeling P: I'm just disgusted with my body, with my thoughts, with my whole existence.
Cognition P: One (I) does not see everything negatively, but simply this, which has to do with oneself.
Cognition P: Just all the problems that we had together I had related to me at that point.
Cognition P: Now things are slowly getting better.

After the Suicide Action Patient, (P), Mother (M)
Action M: Then one time my mother came to my room.
Action M: She then told me that we now had to go to the hospital.
Action P: However, I replied that I didn't feel like it, that I wanted to go back to sleep.
Joint action P, M: There we still almost got quarrel together.
Joint action P, M: I went along after all.
Joint action P, M: Then we ended up in the hospital.

Suicide Attempt 2 Years Ago
Cognition P: (This act was similar in comparison to the suicide attempt I started 2 years ago), definitely.
Cognition P: It had also been in winter, if I'm not mistaken.
Cognition P: The whole process also lasted over a longer period of time.
Cognition P: During half a year I just got worse and worse.
Cognition P: It was actually the same thing.
Cognition P: The only difference is that I really wanted to die then, which hadn't been the case this time.
Action P: I have taken pills and alcohol.
Cognition P: That was the first time then.
Action P: I was still keeping a diary at that time. And when I look in it, I talked about it (suicide) all the time.

Action P: I can read again and again that I have written that I can't anymore, don't like anymore and don't want anymore. Above all, that I can no longer.
Cognition P: The thoughts you have cost an enormous amount of strength if you want to prevent yourself from slipping into such things.
Cognition P: After a month or maybe half a year, you get to a point where you just can't do it anymore.
Cognition P: You can't talk to anyone about the thoughts you have.
Cognition P: I know that I get along very well with my mother, that I get along very well with my two sisters, I also have my therapist, I also have colleagues to whom I could confide all this….
Cognition P: But I know that first of all they can't understand this because they don't feel that way, that secondly I'm embarrassed to say this and that thirdly it's usually already too late.
Action P: I'm always ready to cut myself by then.
Cognition P: I just don't have the strength to talk about it with other people anymore.
Cognition P: At that moment you are so busy with yourself that you don't even think about that anymore.

Sensation During Cutting
Pain P-: I don't feel pain when I cut myself.
Sensation P: Yes, it just burns and bites a bit.
Action P: I cut my tendon there, too.
Action P: I also went out to eat with the cut tendon. I could definitely still hold the fork in my hand.
Sensation P: I didn't really feel it. Everything was just trembling.
Pain P-: You don't have real pain, not like I have now.
Cognition P: One is not quite conscious at all.
Doctors' Action: It all happened so fast. They stitched up my arm.
Action P: Then I fell asleep right away.
Doctors Action: The next morning I was operated.
Pain P: And it wasn't until after the surgery that the pain came.
Cognition P: That clutter in the head has stopped. You know it's still present, but it's like it's turned off.

Present
Cognition P: Right now it's fine. When I'm around people, it works.
Cognition P: But it's worst in the morning and possibly in the evening when I'm alone for once.
Cognition P: The worst is just in the morning when I have to tell myself that I have to get up now.
Cognition P: It's always at that moment that I feel like now then I'm about to explode.
Cognition P: I always feel like I'm about to lose it unless something happens.

Cognition P: But that subsides with time, when in the morning at the station all my classmates are standing around me. Then it works again.
Cognition P: But there are also situations where I really have to restrain myself. That I don't cut myself.
Cognition P: These feelings come especially when I am alone at home and have time to myself.
Cognition P: I was already distracted during school hours. Otherwise I would have cut myself already there.

Prospects and Prevention

Cognition P: … I do hope that this will never happen again.
Cognition P: I think that I myself have to learn to deal with these problems.
Cognition P: I just have to learn that when I realize that everything is starting now, that I then distract myself at that moment. Be it with sports or with another activity that I like.
Cognition P: Or that I can talk to someone, that I can overcome my shame that has always prevented me from doing so. I think that this would help me.
Cognition P: It is my very big problem that I am ashamed to talk about this.
Cognition P: That's still difficult to tell. There are superficial things that I can already tell. But I can't tell my very deep feelings. I can't talk about certain things with my therapist either. I couldn't even confide these things in my diary.

Present

Cognition P: For me, the relationship with the boyfriend is finished. I am still attached to him, or rather to the time we spent together.
Action P: I started therapy again.
Action P-: I don't take any medication.
Action P: I have stopped all medication.
Cognition P: I should try to make sure it never happens again.
Cognition P: But I think now once that this will be very difficult to impossible.
Cognition P: There are just things that throw me off my game, but they don't last that long.
Cognition P: It's just that when my life isn't in balance, I just don't have a fat cushion to fall on. It's all compounded by the fact that I'm always a bit of a nervous wreck.

Disgust and Shame

Cognition P: Yes. It's already stronger at that moment, because then the disgust for oneself also comes. It's just all much stronger, especially when it comes to sex.
Cognition P: It's probably something from the past… Because when a relationship ends, there are just huge feelings of disgust. … It's just all repulsive.
Cognition P: … That can just go from white to black in one fell swoop.
Cognition P: In a sense, I feel abused. All the things I've done with this friend, I've always wanted that too. But in retrospect….
Emotion P: I'm just ashamed.

Resolutions

Cognition P: I'm trying to get a grip on my life so that I feel good about myself, so that I have self-confidence, so that I can go through life on my own again.

Actions P: I'm also getting back into sports.

Actions P-: I stopped all that 2 years ago.

Actions P: I'm starting back up with music, too. Yeah, I'll try it that way.

Actions P: Yes. I use it to build up a cushion again. I can then also keep myself busy when I'm feeling bad and no one is around.

Cognition P: If I can't talk to anyone about it, then I can go to the gym or play the piano. ◄

► **Summary**

1. Within the framework of these long-term and medium-term concerns, the patient describes a series of actions from different areas.
2. She describes her actions and thoughts during the initial suicide attempt and therapy, as well as the termination of therapy. She then tells of her relationship breakdown, the subsequent crisis, the crisis actions and her current suicide action.
3. She then talks about the time after the suicidal action, adds more details about the suicide 2 years ago, describes how she felt when she cut herself, and then talks about her present, her outlook and prevention options, and expresses her feelings of disgust and shame, before formulating her resolutions.

6.2.2 Problems of Action Organization

If we consider the hierarchy of long term and medium term concerns and short term actions, the obvious confusion of this young woman in her moments of crisis cannot be overlooked. The feelings of shame and disgust, which she cannot mentally comprehend, so dominate her that they challenge her bodily integrity as well as her life. The long-term concern to accept and love herself and her actions remains unattainable and the patient is willing to subordinate everything else, even her life, to it. Similarly, the young woman is willing to compromise her long-term concerns with a short-term action. The hierarchy of long-term concerns is not secure. The overarching goals of health promotion and life preservation are subordinated to other concerns. Medium-term concerns, such as the relationship with her boyfriend, shatter vital long-term processes. Short-term actions threaten the successes of long-term and medium-term concerns. Moreover, the order of action in the crisis situation also proves to be dysfunctional. A physical sensation (feeling of pressure) due to an emotion perceived as threatening (disgust) evokes an action that disregards essential life goals (suicidal action). If the patient in a normal emotional state talks about her regulation possibilities, she may very well name sports and other distractions that would help her to get out of this undesirable state.

▶ **Summary**

1. The intellectually incomprehensible feelings of disgust and shame challenge her bodily integrity and her life. The young woman is willing to compromise her long-term concerns with a short-term action. The hierarchy of long-term concerns is not secure.
2. The relationship with her boyfriend shakes her long-term vital processes. Short-term actions threaten the success of the long-term and medium-term concerns.
3. The order of action is dysfunctional in a crisis situation. An emotion that is perceived as threatening (disgust) leads to a physical sensation (feeling of pressure) and evokes an action that disregards essential life goals (suicidal action).

6.2.3 Consciously Prepared or Spontaneously Undertaken?

This type of action ordering problem is closely related to the question of action control, or whether the suicidal action was spontaneous or premeditated. The patient leads us to suspect both modalities. On the one hand, she describes how she carried out the suicidal action 1 day after breaking up with her boyfriend; on the other hand, she describes how cutting was part of her deliberate action strategy in order to get relief from an unbearable tension. Her suicide attempt 2 years ago indicates that she intentionally wanted to kill herself, just as her current suicide action indicates that she accepted death as an unintended consequence of her actions.

▶ **Summary**

1. The patient has a habitualized strategy for relieving internal pressure by cutting, which she uses judiciously, accepting her death.
2. However, she doesn't have suicidal intent until she resorts to a drug overdose.

6.2.4 Problems of the Action Monitoring Processes

When the young woman talks about her suicidal actions, she also describes in detail her problems of action monitoring processes, of action monitoring in her crisis situations. She says that she does not experience cutting her forearm as painful. This means that her sense of pain, action monitoring in relation to pain is overridden in these moments. On the other hand, she describes how she experiences sensations of pressure that call for immediate relief. Behind them are hidden feelings of disgust, but she is unable to deal with them in her emotional experience and thus cannot change them. Her emotional action monitoring also exhibits many problems and inadequacies. Not only does she experience her strong feelings as bodily sensations calling for physical intervention, like cutting, but she also experiences threatening feelings from her childhood in ordinary, albeit upsetting, situations. Both testify to problems in monitoring action through emotions. In addition, her

ability to process strong feelings is also limited. She has to take medication, smokes cannabis and drinks wine for this purpose. There are also gaps in her consciousness monitoring. She tells how her emotional childhood memories with conscious cognitive content are not tappable for her, how she experiences emotions (crying in chemistry class) that are not mentally comprehensible for her and how she finally found herself in a trance state, a state of altered consciousness, while cutting.

▶ **Summary**

1. The patient describes problems of action monitoring for pain, emotions and consciousness, or attention.
2. She feels no pain when she cuts herself.
3. She experiences feelings as physical sensations (pressure), which she can then regulate through physical and chemical intervention (cutting, alcohol, psychotropic drugs).
4. Emotional memories replaced the emotional reflection of the present situation.
5. The monitoring of consciousness is also often altered. Her emotional childhood memories are not consciously tappable, she experiences emotions (crying in chemistry class) that are not mentally comprehensible to her, and she is in a trance state, a state of altered consciousness, when cutting.

6.2.5 Problems of Action Energization

In the young woman's account of her suicidal actions, it is noticeable how she often goes to sleep during the day as well. This means that she cannot energize herself for her usual daytime activities. Moreover, she describes how in states of crisis she cannot discuss her problems because, on the one hand, she feels ashamed, but on the other hand, when the desire is there to cut herself, she can no longer strive for an alternative action "… But I know that firstly they can't understand this because they don't feel that way, secondly I'm embarrassed to say this and thirdly it's usually already too late… I'm always so far gone by then that I cut myself… That's when I just don't have the strength to talk to other people about it anymore." This means that their action energization is fully focused on the self-harming action and another action option cannot be energized.

▶ **Summary**

1. The patient addresses her energizing problems in two contexts. She often has to sleep during the day and cannot muster enough energy to complete her daily routine.
2. She describes how when she is cutting she cannot discuss her state of mind with other people because all her energy is focused on cutting and she lacks the strength for conversation.

6.2.6 Suicide and Interactive and Joint Action

At the moment of the suicidal action, each person is alone and related to himself, which is also the core of the suicidal action. Nevertheless, this young woman also mentions other people whom she directly or indirectly associates with her suicidal action. It is first her boyfriend who questions their relationship. She beats him to the punch by breaking off the relationship and cuts herself massively the next day, requiring hospital treatment. On the other hand, her mother finds her cutting herself in her room and takes her to the hospital. The young woman also mentions her psychotherapy and pharmacotherapy. Although these found certain experiences in the patient's childhood, the occurrence of which repeatedly plunges the patient into crises, she was unable to work through them. Moreover, medication enabled the patient to improve her condition, which was only temporary, but this was not conveyed to her by the therapist. Another encounter or relationship, crucial to the crisis, must be suspected to have occurred in the patient's childhood. The emotional memory of these experiences shakes her to such an extent that she is only able to counter with dramatic means of self-harm and suicide. The embedding of the suicidal action of the young woman in the encounters, relationships and joint actions with others does not mean that the others have to be included in the attribution of guilt, but that joint action, a joint project have to be the way to suicide prevention.

► **Summary**

1. This patient's suicidal action is also embedded in several joint actions and projects. The patient cut herself deeply on the forearm after her boyfriend questioned their relationship. She was then taken to the hospital by her mother.
2. The patient completed psycho- and psychopharmacotherapy, in which communication showed certain limits. On the one hand, the patient discontinued the therapy because she temporarily felt better due to the medication, but she did not address this in the therapy. On the other hand, the patient felt a traumatic childhood experience, but she could not admit it for treatment in the therapy.

6.2.7 The Young Woman's Conversation with a Psychiatrist

In the **first joint action,** the psychiatrist opened the conversation with a frank listing of his motivation for the conversation and then also formulates his question, which is to define the framework of the conversation: "In the conversation we try to find out how best to talk to people who wanted to do something to themselves, whatever it was. We try to understand what was going on inside people before they took that step. I'd like you to tell me how it came about. Because I don't even know what you did exactly, if you overdosed on pills, or if you cut yourself." The young woman takes on this joint task, answers readily, and after further hedging her understanding of the question, she begins to tell in detail what she experienced and had done. She tells of the therapy she stopped, mentions the

memory of her difficult childhood, tells of her breaking off her relationship with her boyfriend and describes the 2 days leading up to her suicidal action. When asked about her thoughts and feelings at the time of the crisis and cutting, she describes fear, disgust, hatred, and shame. In the same joint action, the young woman also describes how she went to the hospital with her mother and was treated there. They also compare the self-harming action recently with the suicide attempt 2 years ago. This allows them to work out the key feelings, experiences and thoughts that repeatedly plunge the patient into crises. The preoccupation with the individual themes and problems, as well as the further development of the patient's narrative through inquiries by the psychiatrist, represent the partial actions and action steps of the first joint action.

In the **second joint action**, they initiate discussion about the patient's future life-protective strategies "I should try never to have another crisis like this. But I now think that this will be very difficult to impossible." However, they can still specify the feeling of disgust and the patient confirms that it is closely related to sexuality.

In the **third joint action,** the young woman would like to summarize the resolutions she has made "I am now trying to get a grip on my life so that I feel good about myself, so that I have self-confidence, so that I can go through life on my own again. I'm also starting to exercise again. I stopped all that two years ago. I'm also starting music again. Yeah, I'm going to try it that way."

► **Summary**

1. In the first joint action, the patient talks about her discontinued therapy, mentions the memory of her difficult childhood, tells of her breaking off her relationship with her boyfriend, and describes the 2 days leading up to her suicidal action. In her crisis, she experienced fear, disgust, hatred, and shame. She describes going to the hospital with her mother and receiving treatment. They also compare the recent self-harming action to the suicide attempt 2 years ago.
2. In the second joint action they talk about future life-protective strategies of the patient. She specifies her feeling of disgust, which is closely related to sexuality.
3. In the third joint action, the patient expresses her intentions and the means by which she would like to achieve them.

6.2.8 The Self-Confrontation Interview

In the **first segment** of the video viewing, asked how she was feeling, the young woman reveals not only her current feelings, but also the impact of the interview on her view of her own problems and how she can prevent the worst from happening. "I still feel really bad, but I still see things a little clearer… I can relate to things better. I also know better now what I need to do to keep it from happening again." She mentions her thoughts of disgust with herself and when she sees herself on screen now, she feels weird: "That also comes from the fact that I have a lot of trouble expressing my feelings to other people.

When I see this now, I feel ashamed. … And when I now look at this, then this is even worse."

In the **second segment,** again asked about her feelings, the young woman described her problem as one of action monitoring "When I tell stuff like that, I don't have a lot of emotions… I'm just like shut down in that moment."

In the **third segment** the patient adds an important piece of information that a year ago she suffered from bulimia and vomited a lot. She again relates this to her feelings of disgust with herself. She attempted suicide with the aim of drawing a line.

In the **fourth segment,** the patient expresses an important thought that complements her statement in the conversation with the psychiatrist. There she mentioned the question of the meaning of life. Now she says: "The question of why one lives is not so important…Because if one asks oneself why one is here, then one does not see the meaning of life. If you think like that, then you don't like to live at all." This can be taken to mean that the question of the meaning of life is not the question that motivated her suicide attempt. If one asks oneself this question, then the action of suicide is already a done deal.

In the **fifth segment,** the patient reports problems with energization: "You are so at the end at this moment. You simply can't do it anymore. Already from the physical point of view you can't get up at all. And I can't bring myself to do something that I know would be good for me… I also have that in other situations where I'm in a bad way, that I just can't do anything anymore. I can't bring myself to do anything that's good for me then either."

In the **sixth segment** she interprets the cutting, the suicidal action as a way of drawing a line, of wanting to get out. She is afraid of the chaos of thoughts, and afraid that they will come back. She characterizes the whole situation as a kind of blackout. She is not only afraid of the chaos of thoughts, but also of "one day I will suddenly hit", that is, that the self-inflicted injury will then become life-threatening.

In the **seventh segment,** asked about her relationship with the boyfriend, she emphasizes her disgust for him and reiterates her relationship feelings about sex. In the partnership, she says, sexual feelings are problem-free, but "…as soon as the relationship ends, then everything is just done. It can fluctuate from extremely good sex to instant disgust with your partner… It might also have to do with the past. I don't know either."

In the **eighth segment,** the young woman said that she would like to cry when talking to the psychiatrist. In the video viewing, however, she comes to the realization that she has to give free rein to her feelings.

In the **ninth segment** the patient summarizes her problem "The whole picture is typical for me. I just tell all this as if nothing had happened… But what I'd like to do is shoot myself again right away. No, that's too crass. If I just let all my feelings run wild, I'd have a nervous breakdown right then and there. That's just typical for me."

Summary

1. In the first segment the patient shows the ambivalence of her experience. On the one hand she sees the problems more clearly and knows what to do, on the other hand she feels bad when she has to watch herself. In the second segment she thinks she can turn off her feelings when she is telling. In the third segment, the patient informs how she suffered from bulimia and vomited a lot because she was disgusted with herself. By attempting suicide she wanted to end this. In the fourth segment she takes up a thought on the question of the meaning of life. She thinks that if one asks such a question, then one is already ready for suicide. In the fifth segment, she comments on her energizing problem, how she was occasionally unable to even stand up. In the sixth segment she describes her exceptional situation of cutting. On the one hand she is afraid of chaos, on the other hand she is afraid she will kill herself.
2. In the seventh segment, she reveals how her disgust is connected to sexuality and how she had experienced the relationship with the boyfriend in this regard. In the eighth segment, she addresses her true feelings and says she wants to allow feelings. However, in the ninth segment she then summarizes her dilemma. She says she tells it like it doesn't move her at all, but she would prefer to die right now. She should allow feelings, but if she let them run free, she would have a nervous breakdown.

Case 5

7

7.1 Suicide Story: Margrit

Annette Reissfelder

He had decided to end their life together – just like that. Despite everything she'd been through with him, and despite everything he'd promised a few months ago. It was like she'd been blindsided. How much of what had mattered yesterday remained intact now? What was left of her life if she had to cut Roland out of everything that made it tick? She had lived for him for the last 20 years, after all – and she didn't say that to portray herself as a self-sacrificing wife. It was just that he was her natural priority. This time he had given her no hope. He'd been all cold and dismissive. Every word had hurt her. He probably wouldn't be back.

He had called her listless! Yes, maybe she wasn't as spontaneous as he was, more introverted. She didn't need much contact beyond what she had at work. Reliability and security were more important to her than having a lot of acquaintances. "Earthy" was what her friend, Brigitte called it, and she had the figure to match. Nowadays such harsh sentiments sprang quickly to mind, but she did not think of herself as depressed. Yes, she was glad to have her rest after a hard day at work. When she was finished with everything after dinner she would relax with an hour's needlework and a peppermint tea. That might not have been exciting, but it was all she needed.

To call that lacking drive was really unfair. She had so much to do with the apartment and the animals. Roland was totally unaware that she did practically everything by herself. He might clear the table once, or mow the lawn, but everything else fell to her. That had never bothered her; she liked to do everything, and was glad that they had such a comfortable life in their home. But what she hadn't realized was that he didn't appreciate it in the

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way she did, and it hit her deeply. He had reproached her for not wanting to do anything in the evenings after a full day of work and housework in the summer! She could think of a couple of occasions during the summer when he had suggested going out in the evenings. That was in July, when she had had a lot of work with the jams. But they were mostly for him, after all – she preferred to eat an egg and cheese in the morning. Later, he hadn't even tried. Only on weekends had they been over to some neighbours' a few times. Well, she would never cook jam again!

She had given to Roland the best of herself. With him she was understanding and generous, relieved him of every inconvenience and irritation. She had felt comfortable and safe by his side. She needed the support Roland gave her. What was life going to be like without him? She couldn't imagine it at all. Yes, he could be a bit controlling, she had to agree with her friends. He was just used to asserting himself at work. It had never bothered her. It even suited her sometimes, so she didn't have to have an opinion on everything. They complemented each other. How they looked as a couple was not so important to her she had finished with that when she had come to terms with the fact that they could not have children.

Not having children was a big advantage right now, Margrit thought. If he left, he would leave nothing behind. She might as well go. Then nothing would remain. No suffering, no nothing. It had all become unimportant. The last few days had called her entire existence into question. She reached mechanically for her knitting. But the almost finished second stocking for Roland made no sense now either; he wouldn't get those socks for Christmas because he would never wear them anyway. She wound up the wool and put everything neatly back into the needlework basket.

As things stood, no one needed her. By now, they were getting along at work without her. She had been there the longest and had the most experience, but her colleagues were a nice and efficient team. Surely they would find a replacement for her.

She had tried several times in the last few days to bring the conversation to her marriage, but Roland always evaded the subject immediately. If she wanted to know something about the reasons for his decision, he broke off the conversation. Once he even left the room. He must have known how difficult it was for her to show herself as vulnerable as she was now, while remaining completely matter-of-fact, even though she was completely at the end of her tether. Not even that moved him. It was humiliating not to be given a chance to understand!

How often had she thought of moments from their life together since Sunday. It was worst in the evenings, when they lay side by side, yet miles apart, in their beds. Three evenings she had spent with bittersweet memories, crying into her pillow. For only beautiful moments came to mind – how was that possible? Perhaps she needed little to be content. They had got along well. She didn't tell him what to do, didn't begrudge him his hobbies, even the motorcycle trips that lasted a week or more. It meant so much to him, it seemed natural to her that husbands and wives should be understanding when the other did things alone. After all, he wasn't gone for long; she could handle a week on her own. Then she met her girlfriends after work, or invited them to dinner, which she didn't usually do. But she wouldn't have wanted a man who worked as a sales representative or was away on

assignment. They had each other 11 months out of the year. Roland was away alone for 2–3 weeks, while she was always at Brigitte's for a week, and at her parents' for a couple of weekends.

Last summer they had had a relationship crisis for the first time in 20 years. He had met a woman on some workshop or training he had done. One day she had sensed that it had become more than a study partnership, and had called him on it. He had acknowledged that they had become close and promised to end it. In August, however, she'd been forced to learn from mutual acquaintances that he'd continued seeing the woman - they'd been spotted together at a restaurant Roland would never have gone to with her. That was when she had confronted him again and told him he had to make up his mind. He had been very clear then – he would stay with her, choose her. She had been proud of herself for bringing about that decision. And she had believed him. A few times she had asked him where he came from, or where he was going. After all, she had to build up trust again. But those instances had remained the exception.

At the end of November, Margrit had gone abroad for a week to visit Brigitte and her daughter. As soon as she had entered the house again afterwards, she felt that something was different. The following day, a Sunday, he had announced that he could no longer live with her. So just over 3 months,late August to early December, he could no longer live with her. Who knows, maybe the relationship with the other woman had been going on all this time! Margit felt quite sick. And he said to her she had controlled him and locked him up! It all just beyond belief!

Even on that Sunday she had wanted to know why he was leaving, what was wrong. And afterwards she had remained steadfast, although he had called her listless and depressive. He said he wanted to be free and unattached again. She had coolly suggested that if he had a new wife, he would be tied down again. He had not responded to that at all. When she added that it must be clear to him that nothing stays new forever, that habits always form, he had simply left her standing in the living room! Since then they had avoided each other when they were both at home, and then today he had left the house completely. He even had his own apartment! That threw Margrit completely off track.

Despite everything, she still liked him and wanted to be with him. If he didn't care about her now, then she didn't care about herself either. He could take the dog, and the cats would find shelter with Mrs. Schwarz, who already had four anyway, and a large property. She told herself that she would really let him go now. She couldn't go on like this. And living without him was unimaginable. So that was how it was now. Fortunately, she knew she had enough – the pills would do. And that was worth a lot.

7.2 Suicide Analysis: I Can't Imagine Living Without Him

Ladislav Valach

The patient described in tears her last days before and after her suicidal action, when she took a medication overdose, and reports that she had been married to her husband

for 20 years and was seriously ill in a wheelchair as a young woman. She wants us to understand her suicidal action in the context of some of her medium and long-term concerns.

7.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

7.2.1.1 Medium-Term and Long-Term Concerns of the Patient

There was, first of all, the "marriage of 20 years" that the husband, after a marital crisis and a new acquaintance, broke up and refused to talk about it with the patient. The patient makes us understand that her husband, whom she loves very much, was her whole life: "I lived for him during that time". She had shared many beautiful moments with him. She could not understand "I just cannot imagine that after 20 years you can say that a person no longer means anything to you." "Then on Sunday he told me he couldn't be with me anymore. … I didn't understand that either".

She also briefly reported on her "illness career" when, as a young woman with a serious illness that has since been overcome, she was confined to a wheelchair and a respirator and had to take morphine. It was then that she had her first "experience with suicide", as she no longer wanted to live with the illness: "That was simply no life for my age of 20. At that time I told my brother that it couldn't go on like this. … That's when I said to myself that I don't have to go through this now." When she was rescued after her second suicide attempt, she became aware of her "suicide trajectory:" "I actually didn't realize until now that this was the second time I'd been on the verge of death."

There are also some long-term concerns that the patient sees as positive in her life that her husband now no longer wants to share with her. This has allowed them to unleash a potential that is straining the partnership relationship. The patient mentions the "full-time job", which gives her a lot of satisfaction and joy. She means "working a lot because we couldn't have children…", "childlessness", but "Working also always gave me pleasure. I still enjoy working today. I really enjoy my work. We are a very great team." She also mentions her "weight problems," her "depressiveness" ("I've always been a bit of a depressed woman. … I'm not an outgoing person. I'm not very good at the spontaneous. I've also always struggled with my weight to this day. I was often depressed.") and her love of "coziness." A crucial role in surviving her suicide attempt was played by her "close relationships with friends," which are very important to the patient. She had maintained these friendships for a long time, and sought to talk to them at the critical moments of her marital crisis, immediately before her suicide attempt. This was not possible because they were absent, but the husband of one of the friends guessed the patient's emotional state and notified his wife, who then sent help to the patient at the last moment. The patient also said that she would not have taken the overdose if she had been able to talk to her friends first. She also had a godchild abroad and visited this friend every year. She also spent a week there in the middle of a marital crisis, which probably allowed the husband to deepen his relationship with the other woman. An important part of her life is also taken up by her

cause, which could now help her get over her loneliness and feelings of abandonment. It is her "love of animals", she has a dog and two cats, "love of reading", and her "needlework". She was able to use these to fill the time when she was alone. Her "relationship with parents" helps her now, as she wants to go there when her husband moves out of the apartment they share. Finally, there is also the question of the patient's long-term concern "to live", which she wanted to give up because she saw it as secondary to her relationship with her husband (my life is only there for the relationship with my husband and if he leaves me, then my life is no longer conceivable).

Long-Term Concerns

Besides the overriding concern "to live", the woman gives even more weight to the 20-year "marriage relationship". She indicates that "weight problems" and "depressiveness" accompanied her for a very long time, or that she dealt with these concerns for a long time. Her "professional life", her work outside the home is also central to her adult life. She associates her 100% employment with her "childlessness". Her friends also represent long-term "friendships" for her. She makes us understand that she thought she was living in a balance of problems and problem solving together with her husband until he suddenly wanted to leave her.

▶ **Summary**

1. According to her account, the patient's suicidal action can only be understood from her long-term concerns and goals. She sees marriage, living together with her husband, as an indispensable prerequisite for her life. When she was seriously ill in a wheelchair in her youth, she saw her health as a compelling prerequisite for staying alive.
2. She describes living for her husband as one of her most important concerns. She also struggles with weight problems and her depressiveness. Her friendships with female friends are equally important to her and the role she attributes to them can be seen from her comment that she would not have taken the medication overdose if her friend had been available by phone.

Medium-Term Concerns and "Projects"

The patient's main medium-term concern was certainly the "relationship crisis": "We just had a relationship crisis. He had met a new woman." The patient tells of his announcement he "wanted to leave" her ("Then on Sunday he told me he couldn't be with me anymore. Then it all went on. I didn't understand that either"), of their "argument" ("There we were discussing and arguing. I wanted to know why he was doing this and what was wrong then. He wants to be free and unattached again. I then told him that if he will now then have a new wife again, that he will then be bound again, only in a different way. This new and different also comes back into a rhythm with time and becomes the old. I don't think I'm so wrong in my thoughts there." "That's when I told him that we still wanted to try it again"), of her "trip to the girlfriend with godchild" ("I then went on holiday to my

girlfriend and godchild for a week"), of her "subsequent encounter" ("I then came home. There I immediately felt that something was no longer good"), of his "departure" ("On Wednesday he then left the house. That simply gave me the rest"), of her "searching for a conversation" ("I then tried to call three colleagues. But none of them could be reached. So I couldn't even talk to anyone about everything") and about her "suicidal action".

How compelling are these medium-term concerns and short-term actions? The wife believed herself safe in a domestic comfort with her husband, but he sought extramarital relations. The announcement that he wanted to move away was certainly preceded by an extended period of time in which he initiated, developed, and maintained this extramarital relationship until they were both ready to live together. And it was only at that point that he informed the wife. She quietly experienced this period of his various absences, bridging it with needlework and reading, and suspected no evil. From her reflections on this event, it is clear that she was in an attitude of entitlement: "He must not just run away. He must be able to identify with it, to stand by it before me… He would still have to stand by me a little in spite of everything…". During this time, following her own habits, she visited her friend and godchild abroad, as she did every year. Should she have stayed home to devote herself to the relationship? Would this have helped? The patient also expresses a fatalistic attitude, "I just told myself then that I'm going to let him go now. I just can't go on like this. I can't imagine living without him either"… After the suicide attempt she said, "I feel very much for my husband. I don't know how to live without him now either." The patient's contradiction between the ultimate activity of a suicidal action and the endless passivity and expectation towards her partner is obvious and surprising.

► **Summary**

1. The patient's long-term concerns were translated into some medium-term concerns. Her relationship with the man was acted out in a relationship crisis, at a time when the man wanted to leave her and when they both had argumentative conversations over days.
2. During this time, the patient traveled abroad for a week to maintain her relationship with her friend and godchild. The day before the suicide, she tried to reach her friends for support in her crisis, but in vain.

7.2.1.2 Short-Term Actions in Medium-Term Projects: Work; Life Together

Cognition P: I actually always worked full time. It's not like we had children – we couldn't have children. That's why I've always worked.
Cognition P: I always loved cozy at home, too. We loved the cozy.
Cognition P: Besides that, we also have three animals; that is, two cats and a dog.
Cognition P: All of this actually filled my daily schedule. I didn't want to do any more.
Cognition P: I didn't need that (emotional gratification) at all.
Cognition P: I didn't mind that, though. I always enjoyed working, too. I still enjoy my work today. I really enjoy my work. We are a very great team.

Suicide Action

After the patient was left without saying goodbye, she still tried, but unsuccessfully, to reach her friends. She later commented, "If I could have talked to someone at that moment, none of this would have happened. I just would have needed someone."

Joint Actions Patient (P), Husband (M): Separation

Action M: My husband told me that he was leaving me, that he could no longer live with me.

Cognition P: (it just came suddenly out of the blue) I just couldn't understand that.

Cognition P: We just had a relationship crisis.

Action M: He had met a new woman.

Joint Action P, M: There We Discussed and Argued

Action P: I wanted to know why he was doing this and then what was wrong.

Action M: He just wants to be free and unattached again.

Action P: I then told him that if he now then has a new wife again, that he will then be bound again, just in a different way. This new and different comes with time also again into a rhythm and becomes the old.

Cognition P: I don't think I'm that wrong in my thoughts there.

Action P: That's when I told him we still wanted to try again.

Actions P: I then went on holiday for a week to my girlfriend's and my godchild's house. I went on this holiday every year.

Action P: I then came home.

Cognition P: Then I immediately felt that something was no longer good.

Action M: Then on Sunday he told me that he couldn't be with me anymore.

Cognition P: Then it all went on. I didn't understand that either.

Action M: Then on Wednesday he left the house.

Cognition P: Then that just gave me the rest.

Cognition P: But when he was normal just gone once, I didn't mind.

Cognition P: But I've always had trouble with being alone. I'm someone who doesn't like to be alone. But I used to bridge the gap with handicrafts. Or sometimes I would go out on a date with someone.

Cognition P: But now there was this finality, this leaving forever in play. I just can't imagine that after 20 years you can say that a person doesn't mean anything to you anymore.

Suicidal Action Patient (P)

Cognition P: I felt an emptiness….

Action P: I then took the tablets soon after. Wednesday… After he had gone away to another woman.

Action P: I then said to myself that I would now let him go.

Cognition P: I can't live like that anymore. I can't imagine living without him either.

Cognition P: For me the decision was clear.

Cognition P: Yes… It was done for me. I didn't want to and couldn't go on.
Cognition P: I had a black wall in front of me. There it was ready.
Cognition P: I feel very much for my husband. Now I don't know how to live without him either.
Cognition P: We've been married for a long time now, too – almost 20 years. I lived for him during that time.
Cognition P: I had already had the medicines at home. But they were well said not for this purpose at home with me.
Cognition P: I just knew that if I took this dose that would be enough. I come from a medical background, after all. I just knew that this would be enough….

Actions: Seeking Conversation, Patient (P), Friend's Husband (MF)
Action P: I then tried to call three colleagues. But none of them could be reached. So I could not even talk to someone about everything.
Action P: The man was at home with one of them. I just told him to give her my regards.
Cognition MF: But the man had noticed that I was not well.
Cognition P: If I could have talked to someone at that moment, none of this would have happened. I would have just needed someone.

Suicidal Action; Patient (P)
Emotion P: But I felt so alone.
Cognition P: That's when I said to myself, it doesn't make sense like that anymore.
Action P: And (when I hadn't reached the girlfriend, then I resorted to the tablets). I did it on that then.
Cognition P: They (the drugs) were in the bathroom – in the medicine cabinet.
Action P: Yes. (I then went into the bathroom).
Action P: I took them right there along with water. Then after that I went back to bed.
Action P: In the middle of the night, I had to get up once to vomit.
Cognition P-: That's all I know.
Cognition P: For a moment I thought about him, that it was nice with him.
Cognition P: We actually had only nice situations – except for this experience here….

Joint Action Patient (P), Colleague (K), Colleague's Husband (MK), Police (Pol), Emergency Team (NT): Patient Is Found
Action K, P: I was found by the colleague.
Action MK, K: The husband of the colleague I wanted to call had told her that I had called. This colleague had already had the feeling in the afternoon that I was very sad. She then simply had the feeling that something was wrong.
Actions K, Pol, NT: She had then called the police. They then came to me. The ambulance also came.

Cognition to Self, Patient (P)

Cognition P: I've always been a bit of a depressed woman. I'm not an outgoing person. I'm not very good at the spontaneous.

Cognition P: I've also always struggled with my weight to this day.

Cognition P: I was often depressed. But I never thought of taking my own life because of it.

Cognition P: I'm more of a quiet person. That already takes a lot of overcoming for me….

Suicide Intention at 20; Patient (P)

Cognition P: I had once (toyed with the idea of killing myself) … But I was only 20 years old then.

Cognition P: That's when I didn't want to live anymore because I was sick. This gave me the feeling that it could no longer go on like this.

Cognition P: I was in a wheelchair. I was then also put on the ventilator.

Cognition P: It just wasn't a life for my age of 20.

Action P: At the time, I had told my brother that this couldn't go on.

Actions P: But I then caught myself again and worked on myself.

Cognition P: But I would never have taken anything or done anything to myself at that moment.

Action P: Yes. Due to the illness I had received a lot of morphine.

Cognition P: Then when I had to go through withdrawal… I just said to myself that I don't have to go through that now.

Cognition P: I actually didn't realize until Thursday that I was on the verge of death for the second time now. ◄

In addition to the suicidal actsion and the medium- and long-term concerns related to the suicidal action, the patient discusses with the psychologist her view of her current situation, her expectations and intentions, as well as her ideas about her future:

Intentions and Expectations, Patient (P)

Cognition P: He can't just walk away from it. He must be able to identify with the matter, to stand by it in front of me. I must be able to confront him with it. He would still have to stand by me a little bit despite everything.

Cognition P: We had been married for 20 years now, after all. He just walked down the stairs and didn't even say goodbye. That's when I just felt that it was now….

Cognition P: I can't imagine it yet… But he's leaving now. He's got his own place. I just have to come to terms with it now, confront it.

Cognition P: If I can get through this, then it's good again.

Cognition P: I had just come home from my best friend's trip abroad. I had talked to her a lot. I also know that now I won't see her again for a long time. We only see each other once a year.

Cognition P: I see the other colleagues in business. That gives me a bit of support again.

Cognition P: I just think of someone on the outside who I trust so much – a good friend.

Present/Future; Patient (P)

Cognition P: Right now I'm trying to deal with myself for once.

Cognition P: I now just have to find a way to manage it all. There are a lot of things connected. There is also the financial aspect. Then I have to think about it.

Cognition P: I just live from day to day. I don't plan anything in advance. I just go from day to day.

Cognition P: I stay where I am. I like it there. After all, it's my husband who's moving out. And when I come home and he's home, he leaves right away.

Cognition P: (It's) a bit dull. I also have a dog, which gives me a lot of comfort. I also read a lot and do a lot of handicrafts.

Cognition P: Then all the questions just come up in me. Why is he indifferent? How can you meet your wife like that?

Cognition P: During the day, these thoughts don't come much. It's already more the case when I go home….

Actions P: Yes. This week I have now arranged something for each day. So I am not at home in the evening and can avoid this problem.

Actions P: Then when I get home, I go right to bed. That's how it all works.

Cognition P: I just need a little time to myself.

Get Help; Patient (P)

Cognitions P: I also have someone I can always check in with. Either with Mr. M (a psychiatrist) or something. There's also a good psychologist where I work. I also have a business card with the phone number in case I get into a slump again.

Cognitions P: I just don't know if everyone would be gone if I needed them again (girlfriends). I can't ask them to stay at home because of me. But I don't think I will do it again.

Cognitions About Medications; Patient (P)

Cognition P: I still have medication at home for headaches. But I don't have this one anymore. I have taken all the tablets of it.

Cognition P: I don't get these at all anymore. You can only get them with a prescription. From here I have been given some by a psychologist or a psychiatrist so at least I can sleep. He gave me very little though. He also told me that it wouldn't do any good if I took them all together.

Actions and Cognitions; Patient (P), Man (M): Present/Future

Cognition P: He (man) is still there, of course. Some time will pass until everything is settled.

Joint actions P, M: Yesterday we definitely broke up again. He was angry with me.

Cognition P: (I wish), That it will be all right again.

Action M, P: He won't let me talk to him.

Action P: I suggested that we go to someone (counsellor) together.

Action M: But he doesn't need that – he doesn't need that.
Action M: He won't listen to reason. I can't... If I just start something like that, he leaves. He then just runs away each time.
Action M: He just says that's my problem.
Action M: He is now moving out of the apartment this month. He is moving into his own apartment this month.
Cognition P: But it would just be important to me if we could talk together once.
Cognition P: I have to give up that hope either way. He won't come back either.
Cognition P: Then I guess I'll go to my family so I won't be home at that moment.
Cognition P: I just have to (prepare myself for this goodbye).
Cognition P: I'm going to my parents' house for Christmas either way now. I told him that I won't be there for Christmas. So I will certainly be going to another city to see my parents then. New Year's Eve, I'm working. So that's when I'll be distracted, that's when I'll be around people. I'll certainly do something with other people there as well. And in the new year I will see then further.
Emotion P: I just like him.
Cognition P: I'll get out of it.
Cognition P: Yes. I'll be working through the day either way. He'll be moving out during the day as well. So I guess there will just be a note waiting for me.
Action M: He also just wrote me a note on Sunday when I left quickly in the morning that he had gone. He always leaves when I'm out with the dog. I don't see him that way.

Suicide Intention Patient (P)
Cognition P: I don't believe it (that I take pills).
Cognition P: …I just can't say with a 100% certainty right now that I wouldn't do it again. I don't think I would. I just wouldn't do it again because of something like that – not because of my husband.
Cognition P: Yes. That's already so (it's just off the table). ◄

► **Summary**

1. The patient elaborates on how she translated the longer and medium-term concerns into actions with thoughts and feelings. She tells about her suicide action in several attempts with new details, about the separation from her husband and about the common actions of the disputes and conversations they had on this topic.
2. She goes on to describe the actions of not reaching her friend in exchange for talking to that friend's husband, the actions of the acquaintances, the police, and the emergency room doctors when she was found and treated.
3. She also expresses several thoughts about herself, describing her actions from her youth when she became ill and suicidal.
4. She then talks about her current intentions and expectations, her future suicidality, and her problem-solving strategies in existentially threatening crises.

7.2.2 Problems of Action Organization

The way the patient describes her relationship and suicide crisis indicates that she held or lived her long-term and mid-term concerns in an order that was not conducive to her survival. She made her life dependent on the continuation of her marital relationship and identified her life with her relationship with her husband, "I lived for him during that time." Then when her husband ended the relationship, she said "I can't imagine living without him either." "I don't know how I'm going to live without him now either…" "But I just felt so alone. That's when I just told myself that it didn't make sense like that anymore." Another unclear or problematic goal order is also indicated by the patient's decision to travel abroad for a week during the marital crisis instead of devoting herself to the concern of overcoming the marital crisis. We might see another type of problem in the patient's organization of action in her living with her husband for many years. She said that she had lived for her husband. To be symbiotically involved in a relationship often results in the omission of communication, which is the thinking and feeling in joint action or projects. The patient settled comfortably into married life. She felt that this suited them both. However, the fact that her husband revealed to her out of the blue that he was moving out shows that the patient thought her own thinking and feeling was the thinking and feeling of the couple. Her husband obviously thought and felt differently. Finally, the patient's action in resorting to pills when she could not reach any of her friends suggests to us that here, too, her organization of action became confused. Of course, we can understand her emotional state, which she could not resolve in conversation. But emotional processes are part of acting, and help shape that acting. It is also of interest that the patient was able to appreciate the effect of the tablets very well, since she works in a health profession. However, she could not visualize the ultimate protection of life, which is the highest maxim in health professions. This is also one of the problems of action organization.

► **Summary**

1. The most important problem of the organization of action also of this patient is that she prefers other concerns to her life, or makes her life dependent on the realization of these concerns. For her, this was living with her husband.
2. Another problem in her action organization was her traveling during the relationship crisis. Although this relationship was more important to her than her life, she still pursued another concern, the maintenance of the relationship with the girlfriend and the godchild.
3. Another problem in her organization of action is evidenced by her confusion of her own thoughts and actions with the thoughts and actions of the couple. Her concern to merge symbiotically with the husband resulted in her mistaking her own thoughts and feelings for the thoughts and feelings of the couple as well as the husband. The couple's thoughts represent their communication, but in this case it was omitted.

4. The final and fatal action order problem is revealed in the patient's inability to desist from her suicidal action without talking to her friend, even though she later says that had she been able to talk to her, it would not have happened.

7.2.3 Consciously Prepared or Spontaneously Undertaken?

Although the patient experienced a time in her youth when she saw no future and had suicidal thoughts, she did not prepare this present suicide attempt long in advance. However, she was preoccupied with suicide when the marital crisis continued to escalate over several days. The thought, "I can't live without him," became more and more entrenched. On the other hand, she sought a conversation with a good acquaintance, but she was not at home and thinks "if I could have talked to someone at that moment, none of this would have happened. I would have just needed someone". But she was not encouraged to commit suicide by the presence of the drugs. She chose death, her suicide, as a serious option to end what she saw as a hopeless situation.

▶ **Summary**

1. The patient developed her suicidal intent during the marital crisis as a problem-solving strategy and did not reach for medication in an uncontrolled outburst of affect.

7.2.4 Problems of the Action Monitoring Processes

Above we pointed out that the patient considered her individual monitoring processes to be the monitoring processes in the joint actions and joint medium-term concerns. This led to misinformation in both joint and individual actions because she did not know enough about the husband's monitoring processes because they did not need to communicate them. The patient also reports with astonishment an exchange with her husband "He says yes, that I was to blame. I would have locked him up. He would have been in a cage for 20 years now. I simply told him that this was a bit strange if he only found this out after 20 years. He would have also at one time… I'm really just not aware that I would have ever locked him up. He could really do anything he wanted."

Likewise, this is also a problem in the patient's actions, as she could not adequately attend to her goals in the relationship. She continued to describe herself as a quiet person, indicating her very sparse and probably patchy communication. This also helped shape their mutual exchanges. In addition, she could know little about her own actions and their effect on her own life because, in her words, she lived for her husband. Another problem of the monitoring processes is also the patient's recourse to her memory of the suicidal intention she harbored as a 20-year-old. We were able to show (Ventrice et al., 2010) that

such experiences promote a suicide attempt. In the critical situation, the person does not adequately monitor the meaning of the given situation, but resorts to a preformulated suicidal intention in memory.

▶ **Summary**

1. One of the most important problems of the monitoring and surveillance systems for this patient is the confusion of her own individual monitoring with the couple monitoring. Thus, she mistook her thoughts and feelings for the couple's thoughts and feelings.
2. The other problem is the patient's recourse to her suicidal experience many years ago. She now experienced the existential threat of that time again, even if this situation interpretation did not apply in the eyes of many others.

7.2.5 Problems of Action Energization

Talking about the emotional energizing of the patient's suicidal action often means dealing with the emotions immediately before the suicide attempt. The patient reported feeling an emptiness that probably drained all her life energy, making her want to commit suicide. However, she associated this primarily with her declared inability to live without her husband. She experienced a lot of emotional energizing in her work: "I really enjoy my work. We're a very great team." When asked if she also found emotional satisfaction at home, she said, "No. I didn't. I didn't need that at all." We can surmise that emotional energizing was lacking in the relationship. While this was not lacking for the patient, she reports how her husband lamented this, "He says yes, that I was to blame. I would have locked him up. He would have been in a cage for 20 years now. I simply told him that it was a bit strange if he only found this out after 20 years. He would have also at one time… I'm really just not aware that I would have ever locked him up. He could really do anything he wanted." This is also a testament to the couple's communication issues mentioned above.

▶ **Summary**

1. The patient leads us to believe that she experienced her actions at work in particular, and possibly her relationships with friends, as energized.
2. She had not sought emotional energization at home. In addition, she describes herself as struggling with depressive states, which indicates her lack of energization.

7.2.6 Suicide and Interactive and Joint Action

In this patient's suicide attempt, too, the importance of joint action, interaction and communication, and relationship cannot be overlooked. This is the case in several respects. First of all, it is the announced separation that the husband was planning, which the patient

cites in her suicide decision. It is then also the soon to be 20 years of living together that the two view so differently. While the patient sees herself as very loving and not wanting to live without her husband, the husband describes the 20 years as life in a cage. Last but not least, it is the patient's emotional integration into her team at work where she likes to go. And finally, it is the shared actions with her friends, whom the patient feels that if she could have talked to them, she would not have taken the overdose of medication. In the end, it was one of her friends who sensed the patient's sinister intentions in the message left behind and, together with police, rescued the patient shortly before midnight. Included in this section, though only peripherally, is the fact that the patient's husband left her when he could no longer keep his new relationship a secret. It is confirmed here that although suicide is based on individual responsibility, suicidal processes are interactive, communicative relational processes, and these must be included in order to understand the suicidal event.

► **Summary**

1. The patient identifies several common actions as crucial to her suicidal action. However, not "being consumed" is common to both. Her husband wants to leave her and her girlfriend is not at home when she called her in her crisis.
2. Nevertheless, this contact becomes life-saving, because the friend's husband and the friend herself suspect something bad and get help in time.
3. The interactive character of the patient's suicidal action also includes the joint shaping of the 20-year relationship. While the woman is content, her husband reveals feeling like he lives in a cage.

7.2.7 The Woman's Interview with a Psychologist

The worried woman accepts the interviewer's task "…what led to her ending up in hospital", and then reports her tragedy in nine short sentences in the **first joint action.** When asked, she adds her feelings of "emptiness," the timing of the overdose, and her thoughts "I can't imagine living without him either." In the **second joint action** she briefly specifies the details of her marriage and reports on the last argument before the suicide attempt. The **third joint action** is about the patient's suicidal action. How she looked for help and did not find it, got her medication and took it, briefly thought about the beautiful moments of the marriage "we actually only had beautiful situations – except for this experience here…" and how she was then found, which she only knows from the reports of others. In the **fourth joint action,** both the patient and the psychologist deal with everything else "…that goes with it (this suicide attempt)." The patient describes herself as depressed, quiet, not spontaneous, and not very sociable. She then recounts her first suicidal intention when she was 20, in a wheelchair, on a ventilator, and in morphine withdrawal, not wanting to live anymore. Now she realized "…this was the second time I had been on the verge of death." An alternative to suicide in such a critical situation as the patient was now experiencing is

sought in the **fifth joint action**. "If I could have talked to someone at that moment, none of this would have happened." It would have to be someone outside the family, but very close to the patient. The **sixth joint action** looks for any open projects the patient may have and she comes up with her work, which she likes very much. She elaborated on this, along with her lifestyle in the **seventh joint action**, recounting her daily life, how in addition to work she took care of her dog and cats, maintained her friendships, and was comfortable at home while her husband was often away from the house. "I just have to find a way to cope with all of this" can be seen as the motto of the **eighth joint action**. In the brief **ninth joint action,** they discuss the availability of the medication. The **tenth joint action** is dedicated to the patient's present relationship with her husband. She wishes "… that it would be all right again, that it would be important to her" … "if we could talk together once." In the **eleventh joint action,** the psychologist tries to explore the patient's current suicidality and to make the patient aware of the non-destructive alternatives. With the **twelfth joint action,** they end the conversation.

▶ **Summary**

1. In the three joint actions, the interlocutors define their task and the patient talks about her relationship crisis, her feeling of emptiness at the idea of having to live without her husband. She briefly specifies the details of her marriage and talks about the last argument before the suicide attempt, then describes the suicide action, how she looked for help and did not find it, got her medication and took it, briefly thought about the beautiful moments of the marriage and how she was then found.
2. In the fourth joint action they deal with what else belongs to this suicide attempt. The patient describes herself as depressed, quiet, not spontaneous and not very sociable. She talks about her first suicidal intention when she was in a wheelchair in her 20s and no longer wanted to live. An alternative to suicide in a crisis situation is sought in the fifth joint action.
3. In the sixth joint action, the patient talks about her work, which she likes very much. In the seventh joint action, she talks about her everyday life, how, in addition to work, she took care of her dog and cats, maintained her friendships and felt comfortable at home, while her husband was often away from the house. In the eighth joint action, she reflects on how she will come to terms with the new situation. The presence of medication, the patient's current relationship with her husband, and the patient's current suicidality are then addressed in the last three joint actions.

7.2.8 The Self-Confrontation Interview

In the joint viewing of the videotape of the interview, the woman in the **first section** reports how bad it is for her to see herself: "…I think it's very bad.", "I think I look terrible…", "…I just feel like I'm very weird on this videotape. I feel like that's not me." When

asked, she denies any discomfort or reservations towards her interviewer in the video interview. In the **second section,** she additionally mentions having thought about "…what will be if someone finds me…" immediately before falling asleep or losing consciousness. She describes her feelings during the interview and then also during the self-confrontation as "…There it was very hard for me. Emotions were already coming up in me then. Now it's not so bad. But it's still…" In the **third section,** she confirmed that even in the video recording she felt the same as she did at the time of the suicide attempt "I feel the same as I did then." Moreover, she offered additional information about how she was angry after the suicide attempt that she survived: "On Thursday morning (Wednesday night overdose) I had a lot of anger towards the colleague for even coming. Today I don't have that feeling as strongly. But I really just didn't want to go on living." Additional information about her life and the husband's extramarital relationship is given by the patient in the **fourth section** "He is doing a school and there he made an acquaintance. Then one day I realized that there was more going on than just going to school with her. He then promised me that he would stop with her. But in hindsight, I just found out that this relationship was going on." "I then told him that it was either me or her. In a three-way relationship, I just don't go along with that. That's when he told me he was going to stay with me. He told me very clearly that he would choose me. I believed him too." "In August, he just told me that he was going to stay with me and that he had made up his mind for me. And now in November he told me that he couldn't live with me anymore. But this now seemed to go on and on. I don't know, maybe I just kept blocking all of that out all the time." Something further about her thought process in the suicidal action is revealed by the patient in this section, "I didn't do it because of him either. But that was just a very short night for me. You can't get more leaderless than that." The importance of having a conversation in a crisis situation, such as the one the patient experienced, is again emphasized by her, "I just don't think I would have done it then (if the girlfriend had been available). When you have someone to talk to at a time like that, it does flatten it out a lot." Talking to her friend, with whom she had lunch before her suicide attempt, she was able to alert the friend to her emotional state, but her suicide attempt was not prevented by this encounter, she adds in the self-confrontation. Fortunately, the friend became suspicious and gained access to the patient's apartment that night. In this section of the self-confrontation, the patient lets us know her ambivalent attitude towards the possible suicide: "Well, the next morning, I wasn't happy that I was still alive." "But I think that the longer it's been since the action, the more you can accept it." "I think that if I was put in the same situation again, I would do it again." "Today, that wouldn't be the case. But if I were to fly into a hole just one more time now…" "If he did it three days later, then I very likely would have done it then. It's certainly the case that it all played together." She adds in this section that immediately before the suicide attempt, she was still having dinner with her husband, they were arguing, and when he left, the patient took the overdose. In the **fifth section** of the self-confrontation, we learn more about the patient's feelings and the problems she still has to overcome in coming to terms with what happened "Even if he said today that he wanted to stay with me, I would still want him." "But I'm the one to blame.", "He's saying I'm the one to

blame. I would have locked him up…" Soon the patient seems to understand the intention of such a statement "I guess that was just to spite me at the end. I guess he wanted it to hurt me even more." but then adds in a balancing way "I would like to say that it always takes two in a relationship. I've certainly made mistakes too." Burgeoning confidence can also be sensed in her reflection "I don't know how I'll speak in six months. Maybe things will be different then." It can be surmised that the conversation, as well as the subsequent self-confrontation interview, are involved in this process. "It was still going through my mind now that it's good to be able to hear it all again." "It makes your awareness stronger. You see everything you've done. I was now just eating it all in all the time and trying to process it that way. But it's becoming clearer to me now this way. It becomes so clear to me what all I've done." In the **sixth section,** the patient reports on her current situation at home. She says the husband is still living in the apartment, will be moving out soon, and they are living wordlessly next to each other. At the end of the video self-confrontation (**seventh section**), the patient lets an additional hope slip through "I just know that I have to go through this now. How it will really go for me then, I will see then." "But maybe in the end I'll be glad when he's gone." "I just realized once again that this is the way it is now."

▶ **Summary**

1. Confronted with the video recordings, the patient makes very deprecating comments about herself in the first section. Then, in the second and third section, she tells how during the conversation she felt the same feelings as in the crisis before the suicide. In addition, she reveals that she was very angry with her friend who saved her life because she really wanted to die. In the fourth section, she informs that she suspected her husband's extramarital affair earlier and they talked about it.
2. The patient then talks about how long it took her to accept that she was alive, how she was learning to observe her situation with her husband from different angles, and how important it was for her to participate in the conversation and video self-confrontation because she could get more clarity about some things.
3. In the sixth section she tells of the present situation at home, and in the last section she hints at a certain acceptance.

Case 6

8

8.1 Suicide Story: A Young Man

Annette Reissfelder

What was the point of life if the one person with whom everything was easy simply disappeared from one's life again, and no one else cared what one felt? In the meantime he was no longer able to switch off his feelings and simply function. Even now, there would have been many things he could have distracted himself with. He had a whole binder of training materials on the table, and he still couldn't tell the models apart for sure… His new company was a good one, he felt supported. The HR manager had put Mr. Brauner by his side on Monday when he had "cried" to her. Mr. Brauner was a kind and experienced man and always took over immediately when he noticed the slightest uncertainty in Marco with the customer. He could not have wished for a better colleague.

When he couldn't be with Monika, he had mostly felt lonely in the last few months – he didn't like living in a hotel, he hadn't settled in well in the new apartment yet. The previous one, where he and Marlies had lived for so long, still had his favorite chair and a few boxes in the basement. He no longer had a key, and would have had to check with her first if he wanted to get his things. But what for – the mess in his apartment had been big enough, not even half the boxes had been unpacked, even though he'd been living there for over 3 weeks despite all the business travel. He had never cooked himself anything proper here. That could be because he hadn't yet found the shoebox of spices he'd packed in a removal box with his pots and pans. And what was the point of buying everything new when he already had it. So far, he had only bought salt for his Sunday soft-boiled egg. Otherwise he had always eaten cheese bread with tomatoes at home in the evening, and cereal with yoghurt and bananas in the morning. That was over now!

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With Marlies, it hadn't been hard for him to accept the end in January. They hadn't been able to talk properly for a long time, just sort of living peacefully side by side before Marlies had started planning her internship abroad. That had been the natural end for him. Marlies had been withdrawing more and more even before that. At some point she had told him that he was clinging to her, and that she wanted to shake him off. And now, he had heard something quite similar from Monika. What was wrong with him? Was he not even capable of being in a relationship that wasn't all about him? Did he really put so much strain on his partners? And he could talk so much more freely with Monika, even about himself!

The spring days with Monika had been so promising and carefree – for the first time he had been able to talk about the things that had been bothering him for a long time, things he had never said out loud even for himself. And, although he had been able to open up with Monika all at once, in the end their relationship had not been positive either, ending before it had really begun. It had been very frightening and unsettling to him that he had overwhelmed her with his problems. It was all so sad – now that he talked, he had lost his girlfriend – and before that, when he hadn't talked, he had been in a relationship for many years. He felt he couldn't go back and go into silence. But the change wasn't taking him where he wanted to go.

Monika had been sweet, and so concerned after he had told her everything right after the suicide attempt – and touched by the fact that he didn't want her to feel guilty. She was still so young, after all! That's why he had written down that neither she nor his mother were to blame. She thought it had been good that he hadn't managed it, not even on the second try. Yes, it was different to shoot at something in training than to turn the gun on yourself. He just hadn't been able to do it. By then he hadn't wanted to, and instead had wanted to go to her and tell her everything.

Even though she had made it clear to him afterwards that they couldn't get back together, that he needed professional help, and again that all that was too much for her, she had made him promise not to try again. Also, the fact that she had told her father everything was, after all, a sign that she still liked him. Her father had spent the whole evening with him, taken the gun away from him and even offered him their guest room for the night.

He had never had anyone he could talk to as effortlessly as he could with Monika, even in this particular situation. He had done everything he had promised Monika: he had been to his family doctor, and even to his HR department. They had been very understanding, and now Mr. Brauner was taking him under his wing. The doctor had also been very supportive. The last week had actually not been too bad. That's why he hadn't thought about having another go at it all week. On the contrary, thanks to Mr. Brauner, he had immediately felt much better at work. In the evenings he had, on the whole, successfully tried to distract himself, and when he noticed that he was starting to brood again, he had spent time with friends and colleagues. He'd also taken the doctor's advice and started putting his thoughts into writing in preparation for their next conversation. By then he was feeling better, but the doctor hadn't had much time, so they hadn't talked about his notes at all. He

had put the crucial things on paper – about his parents' divorce and how alone and disoriented he had felt with only his mother.

The work in the apartment had taken him all day Saturday. He had even found his spice box. It wasn't all finished yet, but the apartment was now completely functional. Sunday had actually been a good day too, first the bike ride with Peter, and then the visit to the mountain getaway for lunch. Only how could he distract himself when he was surrounded by young couples everywhere on the ride and in the pub? The sight of so many happy people had depressed him. He had wished Monika there so intensely, and now thought of her all evening. There were so many things he would have liked to experience with her; they hadn't really got to know each other yet. What could she possibly be doing right now? She was very grown up in many ways, yet very young in others. Her unspoiled freshness had touched him in such a way that he could open up to her without ulterior motives. The fact that Monika didn't want to be with him any longer was a heavy blow.

So now he had pulled out that old suicide note again and put it on the table. He swallowed the pills he still had and lay down on the bed. Surely he would fall asleep any moment now. He couldn't help thinking of his attempt with the pistol a week ago, and remembered the surreal feeling, like when he was a young man and had the measles. Due to the high fever he had seen himself lying in bed over and over again for days as if from the outside – and at the same time it was him in bed. This being there on the one hand, watching himself on the other – an unreal flickering between two worlds. Like last week, when he had walked around in the forest as if he had cotton wool in his ears. Even when he had noticed sounds and said hello to a couple of joggers, he had felt like his body was running ahead and his mind was a few yards behind. Somehow the two had not belonged together. On the one hand, that was a good feeling; on the other, it had scared him. Now he wasn't scared anymore. Whatever came next would be fine, just as it was.

8.2 Suicide Analysis: That's When Everything Fell Apart for Me…

Ladislav Valach

The patient, a young man, 30 years old, tells of his two suicide attempts. Two weeks ago he took an overdose of sleeping pills, after he had already wanted to shoot himself with a pistol 2 weeks before.

8.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

8.2.1.1 Medium-Term and Long-Term Concerns of the Patient

Asked how it comes about that someone no longer wants to live and wants to do something to himself, he describes the days and weeks surrounding his suicide attempts. He embeds the suicidal actions in a series of medium-term and long-term concerns in his life that he

sees in connection with his suicide attempts. These are firstly the 'relationship with his partner' which after 8 years came to a crisis, following which the partner traveled abroad for 2 months. Another long term concern of the young man was his "career" which also underwent a stressful change at the time of his relationship crisis. Of great importance to the patient is his "relationship with his parents", who divorced when he was 14 years old, and which then divided into a "relationship with mother" and one with "father". He lived with his mother, where he felt lonely, however, because his mother worked a lot. The relationship with the father deteriorated and did not improve until late adolescence. The main long-term concern that was challenged by the suicide events was "to live". The young man also mentions his "contacts with his friends", indicating a long-term relationship maintenance. The patient also reports his intense experiences in his "search for identity" over the years, both in youth and currently in the "relationship crisis".

Long-Term Concerns

The most important concern of every human being is, with few exceptions, to get a "life of one's own". The young man subordinated these existential goals to his "relationship with a woman" twice in the last month, or rather made his life dependent on the success of this relationship. He thinks that his excessive demand with "being left alone" or "being abandoned" stems from the experience with the "relationship with his parents". The "divorce of his parents" and "feeling alone" when he lived with his mother left a lasting impression on him. He reported how he felt lost at a young age, "searching for his identity", getting into drugs, which got him into "financial difficulties", but which his father helped him to resolve, enabling the young man to find his way back to him ("relationship with father"). In his "professional career", the patient reports not only about the "new job" he applied for when he realized that his eight-year relationship had ended, but also about his "professional training", which he was able to start thanks to his mother's partner.

► **Summary**

1. To make his suicide attempt understandable, the young man describes some long-term concerns and processes, such as his ending of an eight-year partnership, his career path with a new job, his relationship with his mother and father, his intense search for identity, and his fear of being alone. The long-term concern of maintaining his life was not shown to be the most important thing for him.

Medium-Term Concerns

The "relationships with women" contain an "eight-year relationship with a woman", then a "separation", then the "acquaintance with a young woman". This woman, however, after a "phase of mutual good understanding" felt overwhelmed and "terminated the relationship". The young man's "suicidal event" is also a medium-term concern, as it takes place over several weeks. The "first suicidal action" with a gun follows the "breakup talk" between the two young people. The second, "overdose with sleeping pills," occurs during

a "period of crisis" in which the young man spoke with his supervisor ("talk with boss"), with HR ("talk with HR"), and others, finally receiving antidepressants and sleeping pills from his family doctor ("contacts with family doctor"), which he then overdosed on. The second suicidal action is then followed by the final medium-term concern to "manage this crisis".

We can think of the events surrounding his suicide as individual chapters following the long-term and the medium-term concerns:

1. A medium-term concern was his new relationship with the young woman with the separation.
2. Then came the suicide crisis.

This was composed of:

1. The first action of suicide.
2. The crisis.
3. The second action of suicide.
4. The aftercare.

► **Summary**

1. The young man's medium-term concerns at this time include his separation from his partner of 8 years, his new acquaintance, and the young woman's termination of this relationship. His professional concerns also play a role, as he starts a new job during this time.
2. His crisis, which becomes a suicide crisis, forms an important part of his life during this time. This includes his attempt to kill himself with a gun, his conversations with the young woman's father, his supervisor, the personnel department, his doctor, and his second suicide attempt with the medication he received.

8.2.1.2 Short-Term Actions in Projects

Relationship Crisis

Joint Action: Termination of the Relationship (Patient (P), Ex-Partner (ExP))

Action P ExP: At the beginning of the year, by mutual consent, I ended an 8-year relationship.
Cognition ExF P: We realized we couldn't do it anymore.
Cognition P: That we could no longer speak to each other.
Action P: (There were) issues that had built up with me that I couldn't talk about with my old relationship.
Action ExF: The ex-girlfriend then went abroad for 2 months.

Joint Project: Relationship with the Young Woman; Patient (P), Young Woman (JF)

Action P JF: Met a young woman, (much younger than me), at my old place of work during this time.
Joint actions P JF: Because we had to work on projects together, that's how it turned out.
Joint actions P JF: We then sometimes went out for a beer after work.
Cognition P: And that's when I just noticed that I could talk to the girl very well.
Cognition P: She was very understanding of all the issues that had built up with me that I couldn't talk about with my old relationship.
Cognition P: That may have come from losing her sister to a hereditary disease. The whole family sought help in esotericism after this death.
Cognition P: Somewhere I realized that this girl was listening to me.
Cognition P: I get quite a bit out of that.
Cognition P: That's when a very close friendship was formed.
Joint action P JF: This manifested itself in the fact that we said we would try it together once.

Joint Project with Ex-Girlfriend (ExF)

Action ExF: The ex-girlfriend then came back from abroad
Action P -: and we still had a joint apartment at that time, which I could not terminate because we had a joint contract.
Cognition ExF: When she then came home, she had the feeling that everything was actually fine again, and
Cognition P: for me it just wasn't like that (that actually everything was fine again).
Joint Action P ExF: We had conversations.
Action P ExF: I told her I couldn't anymore, not only because of the new partner, but also because we couldn't talk together.

Project: New Job: Overload; Patient (P)

Action P: At the beginning of the year I had decided to start a new job.
Cognition P: I knew we were going to break up.
Actions P: I moved then, too.
Actions P: I was then abroad for 2 weeks at the beginning because I had to get to know our machines.
Actions P: Although I did come back over the weekend,
Cognition P: but I felt pressured because I hadn't quite moved yet.
Cognition P: I hadn't settled in yet
Cognition P: at the new job I was a little overwhelmed.
Cognition Goal P: I just wanted to do everything justice.
Cognition Goal P: I also still have a very large circle of colleagues that I wanted to cultivate intensively.

Joint Action (P), (JF). (Telephone Conversation): Relationship Crisis – Separation; Patient (P); Young Woman (JF)

Joint Action P JF: During the second week I talked to the new acquaintance on the phone.
Cognition P: (I) noticed that it was not going well, that it was turning sour.
Joint Action P JF: We suddenly had a little argument or disagreement.
Cognition P: It went kind of funny.
Cognition P: Something was bothering me.

Joint Action: Young Woman (JF), Patient (P); Meeting

Joint Action P JF: When I was back, we met up.
Action JF P: And she then said that it wouldn't be right for her that way.
Action JF P: She feels overwhelmed
Action JF P: and (she) also realize that I would have a problem somewhere.
Cognition P: I've noticed that about myself, too.
Cognition P: I had trouble alone in the hotel,
Cognition P: (had trouble with) the new job,
Cognition P: (trouble with) the new apartment.
Cognition P: It was just all too much.
Cognition P: I just couldn't take it anymore.
Joint Action JF P: (adjournment of the separation): But then we delayed it a little bit again.
Actions P: I was then in Switzerland for about a week.

Joint Action: Separation; Patient (P), Young Woman (JF)

Action JF P: Then she said she couldn't take it anymore,
Action JF P: that she was overwhelmed
Action JF P: and that it was probably best if everyone went their own way again.
Cognition P: That's when everything fell apart for me.
Cognition P: Because she gave me a lot of hope.
Cognition P: In all that time, I've been able to tell her so much about my problems, and
Cognition P: she gave me so much.
Cognition P: I kind of like lost my last grip.
Cognition P: I just couldn't put my finger on exactly where the problems were coming from.
Cognition P: I have learned through the new acquaintance to think more emotionally and less rationally.
Cognition P: And that's when it all fell apart for me.

Joint Action: Last Attempt, Definitive Separation; Young Woman (JF), Patient (P)

Joint Action P JF: We then discussed the whole afternoon anyway.
Cognition P: I then felt that we could still give it another try.
Action JF: Towards evening she said that it really could not go on like this.
Joint Action P JF: I brought her home after that.

Crisis; Patient (P)
Cognition P: When I got home, I was completely shaken up,
Cognition P: because I felt like I had nothing left to hold on to.
Action P: I then tried to sleep and that didn't work.
Cognition P: That's when I suddenly started asking myself what this was all about.
Cognition P: I wondered if I wasn't capable of a relationship.
Cognition P: Am I putting too much stress on people.
Cognition P: I am too selfish
Cognition P: think only of me?
Cognition P: It was all building up.
Cognition P: That's when I got into a tunnel where I couldn't see any light. ◄

Suicidal Action; Patient (P)

Preparation of the Suicide Act (P)

Cognition P: Towards morning I had the feeling that I could no longer
Cognition P: and no longer wanted,
Action P-: but I didn't call anyone either.
Action P: I then sat at the table and wrote down my thoughts.
Cognition P: It crossed my mind that it would be best if I wasn't around anymore.
Cognition Plan P: I was thinking that I would just take the gun and go into the woods.
Cognition Goal: P: I just didn't want to live anymore.

Action: Writing a Suicide Note (P)
Action P: I sat down and wrote a suicide note.
Action P: I wrote why I didn't want to live anymore.
Action P: I wrote that I was aware that it was a very easy way to cope and solve my problems.
Cognition P: On the other hand, I also knew that I would make the mother and the colleague feel very guilty.
Cognition P: Somehow it was important to me that I could write that down, that no one else was guilty,
Cognition P: but it comes from me,
Cognition P: because I no longer saw a horizon,
Cognition P: had no more energy
Cognition P: just didn't want to be there anymore.
Action P: I put the letter down,

Action: Departure for the Journey to the Suicide Scene (P)
Action P: Got in the car.
Action P: Drove in the direction of G.
Cognition P: I kind of didn't study anything anymore. The head was empty.
Cognition P: I just had the goal of sitting somewhere and just finishing. ◄

Execution of the Suicide Action P

Action P: Arrangements for Being Informed
Cognition P: Gun I had. But it never used to be an issue (using the gun to commit suicide).
Cognition P: It was like from 1 h to the next.
Cognition P: Subconsciously, I always told myself that now I had written this letter… I knew my sister would be coming home to me next Monday with her child.
Cognition P: She still has to bring me something I asked her for. I deliberately put the letter down so that she had to see it.
Cognition P: I didn't write in the letter where I was going, I only knew then that I wanted to go to a forest.

Actions P: Travel to the Suicide Attempt Site
Action P: I then went towards S. and parked the business car.
Cognition P: The car was pretty heavily labeled (with advertising).
Cognition P: Somehow I wanted people to find me as soon as possible.
Cognition P: What I didn't want was to be lying somewhere and not be found.
Cognition P: I wanted my loved ones to know what happened to me.
Storyline P: I then walked around in the woods for about an hour,
Cognition P: where I met quite a few walkers.
Cognition P: That (seeing walkers) then touched me.
Cognition P: I didn't want anyone to have to witness that (suicide) one on one.

Action P: First Attempt at Suicide
Action P: I then got off the trail a bit and then found a nice spot.
Action P: I then sat on this bench for about an hour.
Cognition P: Then the thoughts started circling again.
Cognition P: I wondered why the girl had left me,
Cognition P: why didn't the other relationship work out?
Action P: I had practiced "dry", meaning I had put the gun to my temple unloaded and pulled the trigger.
Cognition P: At that time I still thought that this was quite simple.
Action P: I loaded the pistol and released the safety.
Cognition Goal P: But then when I wanted to do it right,
Action P-: I had a block.
Cognition P: Somehow the courage has left me.
Cognition P: Something told me it couldn't be.
Cognition P: Most of all, I thought about what would be if it didn't work out.
Cognition P: That had a big impact on me.
Cognition P: What happens if you pull the trigger but get out of there alive, like crippled.
Cognition P: I was very touched by that.

Action P: That's when I put the gun down,
Action P: have secured and unloaded them again.
Action P: I then sat on the bench
Emotion P: (I) was just crying.
Action P-: Though I didn't look at the clock,
Cognition P: but I would say that took about half an hour.

Action P: Second Attempt at Suicide
Cognition P: From far away I heard people again and a dog barking.
Cognition P: That's when I felt like I was in the "real" world again.
Cognition P: Then I drifted off again with my thoughts.
Cognition P: I was wondering what that was all about.
Cognition P: There was no point to any of it.
Action P: I loaded the gun again.
Action P: Went through the whole thing again (pistol to the head).
Action P-: Didn't make it again.

Action P: Aborting the Suicide Action
Cognition P: Suddenly it was like someone hit me in the back of the head.
Cognition P: The thought crossed my mind: what are you doing?
Cognition P: Why do you want to throw that away?
Cognition P: I then thought that this could not be the solution.
Action P: I unloaded the gun again.
Action P: The ammunition packed.
Action P: Then walked to the car.

Joint Action; Patient (P), Young Woman (JF): Conversation After Suicide Attempt
Action P: Journey to the conversation.
Cognition P: I was going to tell someone.
Cognition P: I just wanted to see the girl again.
Action P: I then drove to T,
Cognition P: but don't ask me how.
Cognition P: Suddenly I was then in T.

Action; Patient (P), Young Woman (JF): The Conversation with Young Woman
Joint Action P JF: She was then at home and I told her I needed to talk to her.
Joint Action P JF: I then told her.
Cognition P JF: She's blindsided.
Action P JF: I hurt her very much.
Cognition JF P: She still has very strong feelings of guilt.
Joint Action P JF: I spoke to her on the phone last week.
Cognition P JF: It still weighs on her today.

Cognition P: She is only very young and in a certain way already very advanced, but on the other hand still a child.
Cognition P: But I just wanted to talk to her.
Cognition P: I suddenly had the feeling that I was dreaming,
Cognition P: that the whole thing wasn't true at all.
Action JF P: She did tell me then that it was so that we could not have a relationship under these circumstances.
Action JF P: She told me that she could tell I needed help,
Joint Action JF P: which she couldn't give me.
Joint Action JF P: I would need professional help.
Joint Action JF P: She then told me not to get into any nonsense.
Joint Action JF P: Whether I wanted to come to her home.
Joint Action P JF: I then said that I felt like I wanted to be alone again after all.
Joint Action JF P: But then she asked me for the phone number of my sister and of a good colleague.
Joint Action P JF: I actually promised her then that I wouldn't do anything stupid.
Action P: Then went home again with the gun.
Cognition P JF: I had the gun with me. She knew all that.

Joint Action: (Telephone Conversation); Patient (P), Father of the Young Woman (VJF)

Action P: As soon as I got home….
Joint Action P VJF: did her father call me
Joint Action P VJF: and said that he had noticed that something was wrong as M. (his daughter) was all upset.
Joint Action P VJF: She had told him what had been going on with me.
Joint Action P VJF: He then wanted to talk to me.
Joint Action P VJF: He felt that I really shouldn't be alone.

Joint Action: Conversation; Patient (P), Father of the Young Woman (VJF)

Joint Action P VJF: After three quarters of an hour he really came to me.
Joint Action P VJF: The first thing he did then was take the gun away from me.
Cognition P: That wasn't really an issue for me.
Joint Action P VJF: He then wanted to know from me what had been going through my mind.
Joint Action P VJF: (he wanted to know) why I wanted to kill myself.
Joint Action P VJF: He didn't give me any advice,
Joint Action P VJF: he said that it might be a good idea for me to contact my GP to tell him.
Joint Action P VJF: He then stayed with me for half of the evening.
Joint Action P VJF: He also told me I could sleep in their guest room.
Joint Action P VJF: But I then told him that I needed to be alone.

Action; Patient (P) Sleep Problems
Action P-: Night then I could not sleep again,
Cognition P: but I didn't have those thoughts again.

Joint GP Project; Patient (P), GP (HA)
Cognition P: I knew I wanted to tell my family doctor.
Cognition P: I wanted to get help,
Cognition P: because I knew I had a problem.

Joint Action: Telephone Conversation (P, HA)
Joint Action P HA: I called him then
Joint Action P HA: have described my problem.
Joint Action HA P: He told me to come over.
Cognition P: That actually went well then.

Action; Patient (P) Sleep Problems
Action P-: (Had) not slept again that night.
Cognition P: I no longer thought about not wanting to live.

Joint Action; Patient with Chief (P, Ch)
Action P: I'll be back at work on Monday.
Action P: I should have had a class, but I didn't go to it.
Joint Action P Ch: I went to the office and went to my boss.
Joint Action Ch P: My boss told me I had something.
Joint Action P Ch: I said that I was not well,
Joint Action Ch P: whereupon, however, he said nothing more.
Joint Action Ch P: On the way to lunch he asked me what I had.
Joint Action P Ch: I then told him.
Cognition P: I wasn't afraid to tell him either because I knew him from before.
Cognition P: That's when I noticed that there was a very great understanding.

Joint Action; Patient with Personnel Department (P, PA)
Joint Action P PA: Then on Tuesday morning I had an interview in the HR department.
Joint Action P PA: They were completely surprised when I told them everything.
Cognition P: I actually couldn't keep it to myself anymore.
Cognition P: I used to keep such problems to myself.
Cognition P: I am then shocked myself that I could be so open.
Joint Action P PA: I said that I would accept all the consequences.
Joint Action P PA: I felt that I could not do my job 100%.
Cognition P: I should learn a lot and already go to the customers on my own.
Cognition P: That's why I was completely overwhelmed.
Joint Action P PA: We then had a conversation that lasted almost 3 h,

Joint Action PA P: one then said that the first thing to do was to look on the medical side that I would get help.
Joint Action PA P: The professional should be forgotten a little at first.
Joint Action PA P: They then also provided me with a trained professional to accompany me.
Joint Action PA other P: This person was also informed about my situation.
Joint Action PA other P: He should give me partial tasks, but should also not overwhelm me in the process.
Joint Action PA P: In the company they had the feeling that the job itself was not the problem, but rather the private side.
Joint Action PA P: But you also noticed that it all adds up.
Joint Action PA P: They wanted me to have a prop somewhere.
Joint Action PA P: They wanted to provide me with an environment where I knew I could withdraw if I needed time.
Joint Action PA P: I can tell the experienced person when I am overwhelmed.
Joint Action PA P: But at least I could go to work and not have to stay home where I would fall into a hole.
Cognition P: That did me a lot of good then, that I realized that I had a support.

Joint Actions: Visit to the GP; Patient (P), GP (HA)

Joint Action: Tuesday Visit; (P), (HA)
Action P: I then went to the GP on Tuesday anyway,
Joint Action HA P: who (HA) then said that it still sounded striking.
Joint Action HA P: He then prescribed me medication: on the one hand an antidepressant and on the other sleeping pills.
Joint Action HA P: He felt he wanted to see me on Friday to see how I was doing as the antidepressants wouldn't kick in for another 14.
Joint Action P HA: I then told him that I felt like I was carrying around a problem from before.
Joint Action HA P: I felt I needed to discuss this with someone.
Joint Action HA P: Then he said that he would record it and that I should put my thoughts into words.

Common Action: Friday Visit; (P), (HA)
Action P: That's what I did then.
Joint Action HA P: On Friday he asked me how I was doing.
Joint Action P HA: It kind of worked out.
Action P: I've also been throwing myself into work pretty hard and trying to forget.
Action P: So three to 4 h (I could sleep) and then I was always awake again.
Cognition P: Thoughts have already gone around in circles a bit and kept coming back to the relationship.
Cognition P: I was thinking that this could be good again.
Cognition P: She achieved that I could open up more, that I could talk more.

Joint Actions; Patient (P), Friends (F)
Joint Action P F: The first weekend I went out with friends,
Cognition P: because the family doctor told me that I also have to be alone, but that if I notice that I need someone, that I then call and go out with colleagues.
Joint Action P F: That (going out with colleagues) is what I did.
Cognition P: And that actually went well.
Action P: Then came the Ascention, where I only worked until Wednesday.
Joint Action P F: On Thursday I did something with friends.
Joint Action P F: On Friday, I went to visit a friend.

Actions: Furnish New Apartment; Patient (P)
Action P: And then came Saturday and Sunday, where I hadn't agreed on anything concrete.
Action P: On Saturday, I did a little more decorating of the apartment,
Cognition P: because I felt I needed to create an environment where I felt comfortable again.
Action P: Certain things I have unpacked
Action P: and the rest I put in the basement.
Cognition P: Then I also really had the feeling that I was at home and no longer on a construction site.

Joint Action: Exit with Colleagues; Patient (P), Colleague (K)
Joint Action P K: On Sunday I went cycling with a colleague.
Joint Action P K: We then went out to eat together.
Cognition P: Everything was actually good,
Cognition P: but we also saw many young couples on the beautiful day and
Cognition P: then I related that to myself.
Cognition P: I was thinking that would also be nice if I were out with M. (young woman).
Cognition P: I also wondered what she was doing now.

Action: Evening at Home; P
Cognition P: That night when I got home, I was thinking to myself that it would have been really nice if I had spent the day with her.
Action P: I then watched a little TV…
Cognition P: at about 10 p.m. I felt like all I wanted to do now was go to bed.

Second Act of Suicide (P)
Cognition Goal P: (I) just want to sleep and forget everything.
Action P: I then took the rest of the pills I still had on me.
Cognition P: I did that consciously,
Cognition P: but not with the intention….
Cognition Goal P: I just wanted to sleep,

Cognition P: but not with the intention of not waking up.
Action P-: What else was funny… I didn't throw away the suicide note at the time,
Action P: but kept it.
Action P: Before I took the pills and went to bed, I put the letter back on the table.
Cognition P: On the one hand, I didn't think about the fact that I wouldn't wake up,
Cognition P: on the other hand, I think, as you see on TV all the time too… somewhere I've already consciously perceived that, that I might not wake up.
Cognition P: It wasn't a full intention, but somehow it was there too.
Cognition P: Otherwise I would not have taken out the letter again and put it on the table.
Cognition P: I think the intention was already there somewhere, not to wake up anymore.
Action P: I swallowed that then on Sunday at 10 p.m.
Action P: I fell asleep relatively quickly.
Action P: Woke up on Monday at 8 o'clock.
Cognition P: I was in a weird state but knew I was home.

Joint Action; Patient (P), Business (Supervisor) (G)
Cognition P: Then I realized it was Monday and I had to call the store, that I didn't feel able to go to work.
Action step P G: Then I called the store
Action P G: said that I was not well,
Action G P: to which they said to get back to me the next day.

Action P: Drug Effect
Action P: Then I fell asleep again.
Action P: Somehow I've reawakened.
Cognition P: I felt dizzy.
Cognition P: I was like in a trance state.
Cognition P: I was thinking to myself, "Yesterday you did something stupid."
Cognition P: If I can still do something, I had to do it now.

Joint Action: Telephone Conversation; Patient (P), Doctor's Office (AP)
Action P: Then I called the family doctor again….
Joint Action P AP: But only his doctor's assistant was there. I asked if the doctor was there.
Joint Action AP P: she said he was still at a meeting.
Joint Action P AP: I told her that it would be good if he could call me,
Joint Action P AP-: didn't tell her what it was actually about.

Joint Action: Telephone Conversation; Patient (P), General Practitioner (HA)
Action P: Then I fell asleep again
Cognition P: when the bell rang at 7:30.
Action P: I put my cell phone next to my bed.
Action HA: The family physician called and

Joint Action HA P: said that he had heard that he should call me.
Joint Action P HA: I then told him what had happened.
Joint Action HA P: He replied that of course that was not good at all.
Joint Action HA P: And inquired about my condition.
Joint Action P HA: I told him I was feeling a little embarrassed.
Joint Action HA P: He then asked if I could be alone.
Joint Action P HA: And I replied that I really just want to sleep.
Joint Action HA P: He said that if it was okay, I should come by his house on Tuesday morning.

Joint Action: Tuesday GP Visit; (P), GP (HA)
Action P HA: That's what I did then,
Cognition P: although I was still in a trance state.
Joint Action HA P: He then said that that was already striking, that I had done that with a purpose.
Action HA P: He wanted to pass me on.
Action HA P: He would look at what could be done with the polyclinic.
Joint Action HA P: He thinks it would be good if I went into treatment.
Action HA P: He then also organized this
Action P: I went home again.

Joint Actions; Patient (P), Doctor in Outpatient Clinic (AP)
Action AP P (Policlinic): Then contacted me.
Joint Action AP P: He told me that if someone tried something like that twice, then it wasn't so "harmless" anymore. There was already something behind it.
Action AP P: On the other hand, he has said that if someone really intends to kill himself, he will manage to do so
Action AP P: and I've failed that twice now, thankfully.
Action AP P: He thinks that the will to live is stronger after all,
Action AP P: but that I'm rambling a little bit.
Action P AP: I gave him a little description of how it came about
Action P AP: told him about the thoughts I had written down for myself.
Action P AP: I told him that the thoughts always go back to when I was about 14 years old and my parents got divorced.
Action P AP: They just left me there alone.
Action P AP: I no longer had a caregiver.
Action P AP: I lived with my mother, but she had to go back to work.
Action P AP: My school performance then dropped.
Action P AP: I got an apprenticeship through a friend of my mom's.
Action P AP: I did have a bit of a foothold there,
Action P AP: but somehow I was always alone and always had to fight for myself alone.

Action P AP: Through that, like with the girl, I got too attached to people I cared about a lot.
Action P AP: I also noticed that now with this 8-year relationship when we talked about it afterwards, she also said that she wanted to escape this clinging effect.
Action P AP: Then again with this girl, I was actually constricting her again because of my fears.
Action P AP: Of course, that could happen again in the future.
Action P AP: Because of that, Mr. F. also said that he would welcome it if I would do a treatment.
Action P AP: At the beginning of July I now have an appointment with K. (doctor in P).
Cognition P AP: I feel like there is something there that is weighing me down.

Actions After Suicide Attempt: (Present); Patient (P)
Cognition P: I see it again a little bit now.
Cognition P: What I struggled with in the beginning was the relationships.
Cognition P: Now I've told myself that I'm going to leave the "women" topic on the side for a bit.
Cognition P: That (women) doesn't concern me at the moment.
Cognition P. If I'm already getting this much backing from the company,
Cognition, Goal P: then I will get more involved there.
Cognition P: I also noticed that it works, that I get a lot out of it and learn a lot. Cognition P: I enjoy it, which is why I put more on that track. Cognition P: I'm starting to have a foundation again.
Cognition P: But I also have to say that now that it's been nice again and I see the couples, then it already starts to churn.
Cognition P: The first one I told myself I wasn't going to do that to myself and just went back home.
Cognition P: It's up and down somewhere already.
Action P: I'm sleeping again now.
Action P: Last week, I was still on medication,
Action P: but which I have now dropped this Monday.
Cognition P: Then on Monday it didn't go so well,
Cognition P: but now it's pretty good.
Cognition P: That means if I go to bed at 11 p.m., I wake up around 5 a.m.
Cognition P: And I don't feel like I'm superficially asleep either.
Cognition P: It's starting to come back.
Cognition P: I notice that my head is also becoming freer.
Cognition P: When I notice that something is coming again,
Action P: then I write it down and
Action P: then put the booklet aside again and
Action P: read through it again maybe the next day.
Action P: I'm just trying to clear my head.

Problems in Youth (P)

Action P: So when I was 16 or 17 and looking for stability, I fell in with the wrong crowd and got into drugs.
Action P: Not so much, but the problem of procurement has arisen. With an apprentice's wage it was not enough.
Action P: I then got into debt with friends and
Action P: had also taken out a loan.
Action P: I tried to pay the money back.
Cognition P: When I was a little bit out of it, I felt like I needed a car right now and
Action P: have again incurred debts and
Cognition P: only then realized that I couldn't pay it all back at all.
Cognition P: That's been weighing on my mind and
Action P: I then told this to my partner at the time.

Joint Relationship Project with Father; Patient (P), Father (V)

Joint Action P V: At this time, my relationship with my father also returned to normal.
Joint Action P V: I have resumed contact with him.
Joint Action P V: Something of the first thing I said to him was that I had done a nonsense and
Joint Action P V: had to repay a loan.
Joint Action P V: He then gave me a loan to pay him back.
Cognition P: So then that returned to normal.
Cognition P: But there I also had no perspective for a moment,
Cognition P: because one has always replaced the other,
Cognition P: but even there I always had the will to get out of it.
Cognition P: I somehow still saw a light.

Reflections on the Crisis (P)

Cognition P: I just got scared too when I realized that the girl was overwhelmed when I came with my problems.
Cognition P: That scared me,
Cognition P: that now that I'm talking I'm losing someone and before when I wasn't talking I always had someone.
Cognition P: The crisis was probably triggered by the fact that I noticed that I was changing, but that the change was leading to the exact opposite.
Cognition P: I no longer saw the slightest positive.
Cognition P: Even in retrospect, it scares me that you just can't see yourself anymore.
Cognition P: That made a strong impression on me and
Cognition P: this is still very much on my mind today.
Cognition P: I wonder if you can really fall so low that you don't see yourself anymore.

Reflections on the Mental State in Suicide (P)

Cognition P: (When I took the gun and went into the woods) I'm kind of like back and forth between two worlds.

Cognition P: On the one hand, I was totally there, thinking about whether I was endangering anyone else or whether anyone was watching me.

Cognition P: On the other hand, I've been walking kind of aimlessly through the woods, like I'm in a trance, just with the idea of settling down somewhere….

Reflections on Suicide in the Present (P)

Cognition P: That it's scary to me because I can't quite imagine it. It is still present, but the goal or the desire is no longer there.

Cognition P: Yes, effectively, because I didn't see any other target.

Cognition P: You work towards it again (goals that are more life oriented).

Joint Action P Ch: Just yesterday I agreed with the boss on short-term goals that I want to achieve.

Cognition P: It's the goals that I see then again from today's perspective.

Cognition P: As I said, there are certain situations where it becomes difficult again,

Cognition P: but the thought of breaking up no longer comes.

Joint Action: Telephone Conversation; Patient (P), Young Woman (JF)

Joint Action P JF: About 14 days ago we spoke on the phone again

Joint Action P JF: and I must have said something there that hurt her.

Joint Action JF P: She then sent me an email 3 days later.

(where she wrote that she would welcome it again if we would see each other, but at the moment she just can't, at least not by phone. She has the feeling that I still think that it could become something again with us both, but at the present time it simply cannot become anything and therefore we must keep our distance).

Present Reflections on Friendship with the Young Woman (JF)

Cognition P: Today I also see it from a certain distance.

Cognition P: I think if I allow the distance, I can eventually accept her as a colleague.

Cognition P: I think it would be a shame to break off the friendship.

Cognition P: But right now it's just too early because there are other feelings involved.

Cognition P: Partly (it still hurt) yes, because we had many beautiful moments together and also discussed many problems and were not only cheerful and ran barefoot over the meadows, like lovers. There are beautiful moments that hurt when I think about it.

Cognition P: I'm starting to realize that I can also see it realistically again, realizing that maybe it really wouldn't have worked out because maybe I had a different idea of a relationship than she did.

Cognition P: If I process a little bit of my past, I can possibly counter my clinging behavior a little bit. These are already things where I notice that they repeat themselves.

Cognition P: That's why I would be scared in a next relationship. That's maybe the reason why I don't ride the "relationship" track.
Cognition P: That's definitely so (learned something about herself that I can now change). That is something I give the acquaintance from T. a lot of credit for. By being so open, I have hurt someone, but that also hurts me.
Cognition P: On the other hand, it has opened a door with me where I realize I can come out of myself. That brings me a lot.

Cognition (P) (Conclusion from the Crises and Suicidal Actions)
Cognition P: The further back the suicide attempts go, the more I realize that while it hurts to have to fall so low, it ultimately did a lot of good. I now allow sides of myself that I would never have allowed in the past. That makes me somehow proud that I can allow this, and somehow it also gives me an inner strength that tells me that I have the opportunity and must now grab it.
Cognition P: I'm not saying I already have the solution to everything. It takes a lot more to do that. But it's a piece of the mosaic somewhere that helps me. ◄

► **Summary**

1. The young man describes a large number of actions, joint actions, partial actions and action steps (referred to here as action) in various projects. It is mainly the relationship crisis with the new acquaintance that he describes in detail in several actions, as in the termination of the relationship with the ex-partner, in the relationship with the young woman, in the joint project with ex-girlfriend, in the telephone conversation and the separation of the patient and the young woman, in the meeting of the young woman with the patient, in the last attempt to maintain the relationship and the definitive separation, as well as in the subsequent crisis of the patient. Contributing to this crisis are his actions in the new job, such as being overwhelmed.
2. Other actions he describes concern his suicidal action. This includes the preparation of the suicide action, the writing of the suicide note, his departure for the journey to the suicide site, the execution of the suicide action, arrangements for someone to be informed, journey to the suicide attempt site, first attempt of the suicide action, second attempt of the suicide action and the termination of the suicide action.
3. The actions concerning the time between the first and second suicide attempt: the conversation after the suicide attempt between the patient and the young woman, the telephone conversation between the patient and the young woman's father, the meeting and conversation of the two, actions around the patient's sleeping problems, the patient's telephone conversation with his family doctor, the patient's conversation with his superior, with the personnel department, the patient's visits to the family doctor, the patient's outing with his friends, the

actions around the furnishing of his new apartment, and how he spent the evening alone at home.
4. These actions were then followed by the second suicidal action. After that, the patient talks with his supervisor, with his family doctor and with a doctor in the psychiatric ward.
5. After describing these events, the patient talks about his problems in adolescence, about his relationship with his father, expresses some reflections on his crisis, on his mental state during the suicide attempt, talks about his friendship with the young woman and their last conversation, and then draws a conclusion from his crises and suicidal actions.

8.2.2 Problems of Action Organization

The most important problem in the young man's organization of action in connection with his suicide attempts is surely above all the fading out of the overriding concern "to stay alive". The crises in other, also long-term, but nevertheless normally subordinate endeavors to "staying alive," such as "relationships with women," moved the young man to subordinate his own life to the success of the relationship with his new acquaintance. This gives the impression that the young man possessed or pursued an even higher concern from which he could decide whether to end his life, and which would give him the satisfaction of successful problem solving even after he had deliberately ended his life. This, of course, is not the case. We could see another problem in the organization of action reported by the young man in the close connection between his experiences in the "relationship concern with his parents", or his mother – in which he experienced the threat of separation and the subsequent "feeling lonely" – and his organization of the relationship concerns with his partners. These relationships, in a positive sense, in the maintenance of the relationship, as well as in the separation, are not to be confused with the relationship concerns with one's parents, or one's mother. The young man came to the realization that he was developing his relationships with women, particularly the last relationship with the young woman in a way that was threatening to her because she experienced them as clinging. This, he said, was the result of "feeling lonely", which he knew from his adolescence. However, it remained elusive to him that the existential angst he experienced at the time of the break-up could also stem from this time. The conscious separation of these long-term relational concerns – relationships with parents, relationships with partners – represents a helpful organization of action. We can see another problem in the action organization of the processes the young man describes in relation to his suicide attempts in the organization of his relationship with the young woman. The patient describes how he was able to open up to the young woman and talk about his feelings. This is certainly to be welcomed, but it can be surmised that he was only marginally concerned with organizing his relationship with the young woman because he was too consumed by his own change. In

conclusion, the action organization around the suicide event must also be considered directly in terms of its problems.

For example, after the young woman broke off the very short relationship, the young man said, “everything has collapsed for me” and “I have somehow lost my last hold”. This means not only that he tied the meaning of his life to the success of this relationship, as discussed above, but that instead of dealing with this feeling constructively, he only deepened it with thoughts such as “I am not capable of a relationship”, “I burden people too much”, “I am too selfish”, or “I only think about myself”. With these thoughts he went to sleep, which didn’t work, and in the morning he built up not only the comprehensive statement “I can’t do it anymore”, but also the intention “I don’t want to do it anymore”. Following this, he wrote down his thoughts, the destructive side of which he probably deepened, and concluded “that it would be best if I were not there.” It may be that he is implying to others that they wish he were not there. We recall: the parents separated, the mother had little time, and the patient felt lonely and probably abandoned and unwanted. He experienced the rejection by the young woman, in the absence of a clear separation between the relationship with his parents and with his partner, also as her wish that it would be better if he were not there. The problem of action organization in this case is the adoption of the supposed goal of the other. In other words, “since I want to secure their affection, I comply with their wishes”. Their desire is “that I should not be there.” From the indefinite “not to be there” he formulated his goal “I just didn’t want to live anymore”. These are not only mental misconceptions, but concrete problems of acting, which the patient also lived tangibly and observably. Not only could he not sleep, but he lived out these thoughts. He sat down at the table and wrote a suicide note. In this letter he protected himself from possible accusations that his suicide was a very easy way to cope and solve problems. From a person who saws at the branch on which he sits we say not only that he or she makes a mistake in thinking, but that the whole action is wrong. This is not a successful way to acquire wood. From this way of coping with or solving problems, one can only read a defective way of acting. The hierarchy of goals is problematic, the means-goal relationship is not right, the control and regulation processes are off, because the test for success has not been made. The most important concern of the patient at this moment was to absolve both the mother and the young woman of any guilt for his suicide through his suicide note.

The patient very aptly describes the switching off of all inner action processes on the way to the suicide scene as “the head was empty”. This means that all inner processes of action were switched off or not mirrored or not monitored. This is not a good condition for optimal action. It is an action problem. He had only one goal in mind, “to sit down somewhere and call it a day”. Another thought the patient expresses points to his dichotomy described earlier, as if he was “puppet and puppet master at the same time.” In fact, when he committed suicide, he set other goals that were important to him. “I wanted people to find me as soon as possible”, “I did not want people to witness my suicide”. The patient points out the lack of conditions for his continued life as “I saw no more horizon”, “I had no more energy” and “I didn’t want to be there anymore”. One could say he saw no longer-term goals that would promise a hope of success, and since he also felt no energy, he

wanted to withdraw, or stop the journey, as if life were one trip among many. This is not a philosophical problem, but an action problem. As the patient sat on a bench in the woods, pistol in hand, his rational thoughts returned. However, it was not in the form of an orderly problem-solving process in which, for example, the problem, the possible solutions, the weighing of means, and the planning of the course of action would be considered in sequence, but the patient described the process as circling thoughts. This is again an action problem. The patient was able to eliminate many processes in his actions in the suicide, but some ingrained automatisms remained. Then, when he brought the loaded gun to his head and tried to pull the trigger, which worked fine with an unloaded gun, suddenly "blocks" that he probably memorized while learning how to use a gun came up: "loaded gun can hurt" and he could come out of this process as disabled. The idea of himself as a helpless, disabled person moved him greatly. The strong disconnect between his different systems of action is illustrated in another experience he describes. After he freed himself from the emotionally moving idea that he could be disabled, he heard people who, in his words, brought him back into the "real world". In this real world, he said, everything was meaningless to him, he was not wanted, and so he was able to load his gun again and bring it to his head. This time, however, the security automatics reached him not only emotionally, but also in his decision-making ability. Now he was suddenly capable of considering other possible solutions. He described this turnaround as "if someone had hit me in the back of the head." So he experienced this opening in his action system almost physically as a blow to the back of the head. This proved to be life-saving, because suicide attempts with a gun are very often fatal. All of these problems are problems of action. The overarching, longer-term concerns were lost in favor of trying to fix the short-term grievance. The usual problem-solving strategies that the young man used successfully in other areas of his life were suddenly unavailable.

▶ **Summary**

1. The most important problem of the order of action in this patient, as in many suicidal people, is the fading out of the overriding concern to "stay alive." He subordinated his life to crises in relationships with women.
2. Another problem in the organization of action is the close connection of his experiences in the relationship with his parents, or his mother, (with the memories of the threat of separation and "feeling lonely") as well as his relationship concerns with his partners.
3. Further problem in the organization of action we can see in the formation of his relationship with the young woman. The patient was able to open up to this woman and talk about his feelings. One could assume that he was only marginally concerned with the shaping of the relationship with her because he was too absorbed by his own change.
4. The suicide event itself also shows some problems of action organization. After the termination of the relationship everything collapsed for him and he lost the last support. Instead of dealing with this feeling constructively, he deepened it

further with thoughts like “I am not capable of a relationship”, “I burden people too much”, “I am too selfish”, or “I only think about myself”. In the morning he stated “I can’t do it anymore”, “I don’t want to do it anymore”, and “it would be best if I am not there”. The problem of organizing action in this case consists in taking over the supposed goal of other people.

5. The patient shuts down all internal action processes on the way to the suicide scene (“The head was empty”).
6. Another problem of action organization is evident from his description of having been “the puppet and the puppet master at the same time.”
7. On a bench in the woods, pistol in hand, he experienced a “circle of thought” instead of proper problem solving.
8. Other problems of action organization proved to be life-saving, such as ingrained automatisms (a blockage when he wanted to pull the trigger on the pistol), or when the emotional anticipation of future conditions (he would be disabled) brought him back into the “real world” and he was able to consider other possible solutions.
9. In the self-confrontation interview, he describes his state of consciousness during the suicide attempt as alternating between trance and reality, in which the organization of action was severely impaired.

8.2.3 Consciously Prepared or Spontaneously Undertaken?

From the above information it can be concluded that the patient consciously prepared his suicide attempt, for he wrote a farewell letter and chose a suitable place for the suicide in the forest. It may be that the vital energy and zest for life, as well as the meaning of life, disappeared relatively quickly after the breakup with his brief acquaintance, as if an old wound were opening up, pulling the rug from under his feet. Nevertheless, the change from a life-affirming project to a suicide project in his case can certainly be seen as a top-down steered process. This is also evidenced by his persistence in trying again a few days later and taking a medication overdose.

The bottom-up steering of the switch between these two projects happened when he suddenly realized, as if with a blow to the back of the head, that he didn’t actually want what he was doing. So he was back in his life-affirming project and could initiate appropriate actions.

► **Summary**

1. The patient deliberately prepared his suicide, although the separation from his new acquaintance suddenly plunged him into an abyss.
2. His interruption of the suicidal action, however, was a spontaneous, unprepared, and impulsive action.
3. The persistence of his suicidal intentions also attests to his top-down conversion from a life-affirming to a destructive project.

8.2.4 Problems of the Action Monitoring Processes

The suspension, or malfunctioning, of the self-monitoring and action-monitoring processes is evident from the young man's account. It is first of all his monitoring of the rejection by the young woman that he perceives from an emotional memory and not from the momentary situation in which he finds himself. He experiences this as an existential threat rather than a termination of a new and very brief relationship. This is certainly complicated by the fact that after his experience in early adolescence, the young man adopted a monitoring strategy, or a way of dealing with his feelings, which he believed he could use to protect himself. Then, when he was able to open up emotionally in the brief relationship with the young woman, he was rejected ("…now that I'm talking (about his feelings) I'm losing someone and before, when I wasn't talking, I always had someone.").

However, the strategy of not talking about his view of the problems and his feelings was also not constructive for a relationship in the long run. The young man reports that the eight-year relationship ended because they "could no longer talk to each other". He goes on to say, "(There were) issues that had built up with me that I couldn't talk about in my old relationship." These are first of all problems of emotional self and action monitoring. The impairment of cognitive processes in perception and interpretation of the situation in which the young man found himself has already been addressed above. Not only was he unable to solve the problems at hand and he saw himself in the shambles of his life, he described his thinking, perception and state of mind as, "That's when I entered a tunnel in which I no longer saw any light." When the young man had written the suicide note, put it down, got into the car and drove to the suicide site in the woods as, "(t)his head was empty". This, too, a severe disturbance of cognitive self and action monitoring. In self-confrontation, he describes dissociative experience when he saw himself as running body and mind separately. The patient dramatically describes alternating between "turning off" and "turning on" the self and action monitoring system. When he sat in the woods and practiced shooting with a secured unloaded gun, nothing registered. However, when he tried with a loaded gun, the self and action monitoring system was suddenly back. What showed up only as "inhibition", and "blockage" on the first attempt with the loaded pistol, was associated with an alternative action on the second attempt. The young man suddenly saw the nonsense of his actions and had another option for action. Similar problems of the self and action monitoring system can be seen in his second suicide attempt. The patient reports his ambivalence of intention when he took the overdose of sleeping pills. On the one hand he said "(I) just want to sleep and forget everything", on the other hand he said "I then took the rest of the pills I had with me. I did that consciously", "I didn't do that with the intention of not waking up anymore", "somewhere I was already consciously aware of that, that I couldn't wake up anymore", "I think the intention was already there somewhere, not to wake up anymore".

Summary

1. The young man talks mainly about his consciousness and emotion monitoring problems. He monitors the rejection by the young woman from an emotional memory and not as a here-and-now situation. He describes a problem of action monitoring in joint action with his long-term partner as "we couldn't talk to each other anymore." "(There were) issues that had built up with me that I couldn't talk about in my old relationship". Not being able to talk in joint action is comparable to a problem of awareness in individual action.
2. The patient reported many monitoring problems when describing his suicidal actions. He felt as if he was in a tunnel in which he no longer saw any light. This is a narrowing of consciousness, thus a problem of action monitoring. He felt that when he drove to the suicide scene in the woods his head was empty. He experienced himself as divided, getting ahead of himself. His action monitoring was as if turned off. The patient also dramatically describes the alternation between "turning off" and "turning on" the self and action monitoring system. This moved him to repeatedly put on and put down his gun. He experienced something similar in his second suicidal action when he overdosed. What he experienced as ambivalence was again this "turning on" and "turning off" of his monitoring.

8.2.5 Problems of Action Energization

Our feelings are not only effective in their function of self-monitoring and action-monitoring, but are also necessary as action-energizing. Many suicidal individuals reveal problems in action energization. The young man reported how he wrote the suicide note and concluded that "he had no energy left." Previously, he also lamented that he had "trouble alone in the hotel," "(trouble with) the new job," "(trouble with) the new apartment," "It was just all too much." It was certainly not just intellectual overload, but more importantly a lack of energy. He experienced a problem in action energizing after the rejection by the young woman. His feeling of "I couldn't take it anymore" expressed not only being "at his wit's end" but also, more importantly, not experiencing any energy. When the young man describes how courage left him during the first attempt with the loaded, unfired gun, he also makes us feel that the energy for the suicidal action, for the last action step was suddenly missing. After the abort of the second attempt with the loaded gun, however, not only did the blockage due to the monitoring of the situation arise, but also a new alternative action and the energy to carry it out. The patient packed up the gun and went back to the car. A problem of action energization, though not a deficiency but a surplus, can be seen in the young man's sleep problems. Whenever problems experienced as existential weighed on him he could not sleep. The attempt to overcome this with sleeping pills eventually led to his second suicide attempt.

▶ **Summary**

1. The young man describes the time after the rejection by the young woman in his suicide note as "he had no more energy". He had "trouble (being) alone in the hotel", "(trouble with) the new job", "(trouble with) the new apartment", "It was just all too much". This was mainly a lack of energy.
2. Problems of action energization also became apparent during the suicide attempts. It was not only the lack of energization, but also division of this energy between living and dying, which he experienced in a back and forth.

8.2.6 Suicide and Interactive and Joint Action

The young man interpreted his suicide attempts in the context of his relationship problems and it is therefore important to note the joint and interactive action. He reported how the knowledge of his parents' divorce, his loneliness when he lived with his mother, his difficulties in his relationship with his father and how he found his way back to his father through his problems helped to understand his suicidality. He makes a direct reference to the rejection by his new acquaintance, the young woman by whom he initially felt very understood and who helped him to open up. Immediately after the breakup talk, the patient rushed home broken, and after a sleepless night, he decided to depart from life and wrote a farewell letter – again an interactive action. In his suicide note, he attempted to dispel any feelings of guilt from his mother and his new girlfriend, and to take responsibility for his suicide. When the young man was looking for a suitable place to commit suicide, it was important to him that he would not be observed in the process and could thus spare possible onlookers an unpleasant experience. On the other hand, he also did not want to go to a very remote location so that he could be found soon. After aborting his suicide attempt, he rushed back to his girlfriend to tell her about it. Thereafter, her father contacted him to have the gun handed over and to condemn his suicidality. The patient then called his family doctor, attended a GP appointment, spoke to his boss, to HR and finally to a psychiatrist at the policlinic.

▶ **Summary**

1. Both of the young man's suicide attempts are firmly embedded in joint actions with others. These serve as the origin, accompaniment and consequence of his suicidal acts.
2. He sees the origin of his suicidality in the broken relationship. He understands his feelings of rejection and isolation from his childhood experience with his parents. In the second suicidal actin he took sleeping pills and antidepressants, which he received from his family doctor shortly before.
3. He began his suicidal action by writing a suicide note in which he wanted to exonerate everyone else. At the place of the suicide action, he paid attention to

other people so that he would not worry them with his actions. But he also wanted to be found soon.

4. After aborting his suicidal action, he talked to his girlfriend, her father, the family doctor, his boss, the human resources department, and finally a doctor at the psychiatric clinic.

8.2.7 The Young Man's Conversation with the Psychiatrist

Even though the young man describes his experiences and actions surrounding the suicide event in a very competent, detailed and orderly manner, his narrative is not only his view of the events he experienced, but also a product of the joint action with the psychiatrist, the conversation.

The psychiatrist offers the young man a lot of space so that he can present his experiences. He does not try to impose his own order on the patient.

In the **1st joint action,** the psychiatrist formulates the task, requiring the patient to complete, or correct, the data, since it involves two suicide attempts in the last 4 weeks.

In the **2nd joint action,** the psychiatrist formulates the task again, the young man takes it over and implements it. The psychiatrist understands his task as understanding, attentive listening. The young man is able to narrate uninterruptedly the time leading up to his first suicide attempt – he describes a period of about 4–5 months. When he then gets to the point where, according to him, he was sitting in the woods with an empty head and wanted to commit suicide, ("I just had the goal to sit down somewhere and just finish") he made a short pause (**3rd joint action**), which the psychiatrist used to ask for confirmation of a statement ("And you had a gun in the house anyway?"). The patient explains the circumstances of having a gun at home, and the psychiatrist formulates the patient's next action step for confirmation to get the narrative going again ("And afterwards you went to the woods?").

In the **4th joint action** the young man reports about his further actions in the time around the suicide. When he then reported about his visit to his girlfriend after the aborted suicide attempt, in which he told her everything and she sent him back home, (**5th joint action**) the psychiatrist wanted to know if he still had the pistol with him at that time, in order to understand the dangerousness of the situation (patient "…(I) then went back to I." Psychiatrist "With the gun?"). In this section, the young man recounts other incidents and how he came to terms with his critical situation. He describes how after the GP visit, where he was prescribed antidepressants and sleeping pills, he threw himself into work and tried to forget. The psychiatrist initiated the next, **6th joint action** by asking if the patient could already sleep, anticipating that this might contribute to the worsening of the patient's crisis. The patient tells how he tried to cope with his difficult situation, felt exhausted and took an overdose of sleeping pills.

The psychiatrist together with the young man tried to clarify the question **(7th joint action)**, to what extent the patient took the sleeping pills with the awareness of the fatal

consequences. To stimulate the continuation of the patient's narrative, the psychiatrist asked "Then what happened afterwards?" (**8th joint action**). In this section, the patient then narrates from the second suicide attempt by sleeping pill overdose to his interview with a psychiatrist in the psychiatric ward, as well as his upcoming interview with a psychiatrist. After the patient's story has come to a natural conclusion, the psychiatrist takes the lead again, evaluates the narrative positively and inquires about the patient's current state **(9th joint action)** (how he feels, that it is good that the patient is more concerned with his professional career and not with relationships with women, whether he is still taking the medication, how he sleeps).

In the **10th joint action,** the psychiatrist asked about the biographical history of his suicide, whether there had already been a time when he "…didn't see any further, didn't have any perspective". The patient then recounts his adolescence, when he felt lonely after his parents' divorce and later got into financial difficulties due to his drug use. In the **11th joint action,** the psychiatrist connects this experience of the patient with his present experiences and the suicide crisis, which the patient also confirms. In the **12th joint action,** the psychiatrist tests with the patient the proposition that the patient's whole identity was affected in the suicide crisis. The psychiatrist then initiates the conclusion of the conversation by introducing the topic of how far suicidality still played a role for the patient at the present time, whether the suicide goal was still in question, whether the circumstances of the suicide were now different, whether the experience still hurt, and that it was possible to "normalize" what had been experienced. The psychiatrist introduced the **13th joint action** with the question whether "…in the end the story (has) also brought you something? You learned something about yourself that you could change now?", to which the patient answered in the affirmative and elaborated.

The insight into the process of how the patient's suicide story came about in his narrative in conversation with the psychiatrist is relevant, as it becomes apparent that the most important background to understanding the young man's suicide, the experience of loneliness in youth, was only addressed through the psychiatrist's inquiry. Moreover, the patient also formulates the influence of the narrative on his understanding of the experience. He said "Somehow I go through the whole thing again in the narrative, but realize that it's scary to me because I can't quite imagine it. It's still present, but the goal or desire is no longer there."

► **Summary**

1. In the 1st joint action, the patient and psychiatrist agree on the task. In the 2nd joint action the patient tells about the 4–5 months before the suicide attempt up to the moment when he was sitting in the woods and wanted to commit suicide. In the 3rd joint action they clarify the presence of the weapon.
2. In the 4th joint action the young man tells about his further actions during his suicidal period, about his visit to his girlfriend and how she sent him home again. In the 5th joint action, the young man describes further incidents of how he threw himself into work and tried to forget after the visit to the family doctor, where he

was prescribed antidepressants and sleeping pills. In the 6th joint action the patient tells how he tried to cope with his difficult situation and took an overdose of sleeping pills.

3. In the 7th joint action they both try to clarify whether the patient took the sleeping pills knowing the fatal consequences. The patient describes the suicide attempt with an overdose in the 8th joint action. He also tells of his conversation with a psychiatrist in the hospital.
4. In the 9th joint action, they discuss the patient's present condition, his professional ideas, and his relationship desires.
5. In the 10th joint action, the patient describes his youth – how he experienced the divorce of his parents and resorted to drugs. In the 11th joint action, they discuss the connection of these experiences to the current suicide crisis. In the 12th joint action, they discuss how the patient's identity was challenged in the suicidal crisis and the extent to which the patient is still suicidal at present.
6. In the 13th and last joint action, they try to draw a conclusion from this suicidal crisis. The patient also formulates his gain from the detailed conversation about this time, as well as its antecedents.

8.2.8 Self-Confrontation Interview

The patient sometimes has great difficulty watching the video recording. Over larger sections he looks to the floor and seems very introverted. So there are only a few sections available.

In the **first section,** the patient comments on his feelings during the interview and the effect of the repeated narration "…but I (have) already gained a little distance, because I have talked about it with several people. I can tell it, like a story, but inside it still stirs me up quite a lot… when I spoke to the HR manager at the beginning, it was less talking and more crying. At the time, I could barely say a word without crying right then and there… I'm struggling already, but at least I can tell it in a flow. I think the more I tell it, the more open I become, too, in that I'm moving away from it more and more, too." In the **2nd section** he describes his present state of mind and expresses his astonishment at how devastated he was on the one hand, and how many thoughts he could nevertheless put forward "… I had no strength left… In one way I am shocked at how low I had sunk at that time, and on the other hand I am also amazed at how many thoughts I had about it… how rational I still was at that time, although I no longer had any will to live". In the **3rd section** he makes several observations. He wanted to prevent outsiders from observing his suicide, then he came up with thoughts about the consequences of a failed suicide and living with brain injury, and finally he describes his state of consciousness at the time of the suicide attempt as alternating between trance and reality. He also addresses the inner turmoil in the **4th section.** It was not only the alternation between trance and reality, but also a back and forth between his suicidal intentions and the doubt if it was the right thing to do and what

would happen if he stayed alive brain injured. So it was also not only an alternation of cognitions but also an alternation of emotions. In the **5th section** he is still trying to explain his state of consciousness. The question he asked himself why it didn't work out with the relationship led to a state of mind as if he had cotton wool in his ears and "… as if the body was running ahead and the mind was coming 5 m behind. I was running parallel with that. They didn't belong together somehow". He reported that he knew this feeling. It was a "feeling I had once before several years ago when I had the measles. I had a fever of 40 ° for three days and then I saw myself lying in bed from the outside".

► **Summary**

1. In the first section the patient expresses his feelings in conversations after the suicide attempt, in the conversation with the psychiatrist and also in the self-confrontation interview and says that although he has been able to gain a lot of distance, because in the first conversation he could only cry, his story still moves him.
2. In the 2nd section he shows himself amazed at how low he had fallen at that time, had no energy, and with what rationality he made his reflections.
3. In the 3rd section he talks about his thoughts during the suicide attempt. How he wanted to avoid having witnesses and how he feared surviving the suicide attempt as a disabled person. He also describes his state of consciousness as alternating between trance and reality.
4. This conflict was also evident in his intentions to die on the one hand and his desire to live on the other.
5. In the 5th section he explains the state of consciousness of that time as "cotton wool in the ears" and "the body runs ahead and the mind five meters behind", "I did not belong together". He knows the state from a previous illness with high fever, when he looked at himself from the outside, so to speak.

Case 7

9

9.1 Suicide Story: Nicole

Annette Reissfelder

Nicole lit a cigarette.

Pia:	Didn't you quit smoking when you moved into the big apartment?
Nicole:	Oh dear, that was a long time ago, we've been living here for half a year now. I lasted 21 months, but the day Daniel moved out, I bought some again. Oh Pia, it's so good to have you here! Thank you for coming, Pia.
Pia	I was going to stop by on my way back in February, since it's practically on the way, but then something came up. Anyway, I'm glad I called today. You sounded awful on the phone. Where are the boys?
Nicole:	Thomas only has football and his clique on his mind. I don't know when he was last at home in the evening! And Markus is usually at his girlfriend's, she still lives at home too, but he likes being there, he likes her brothers and her father. It's good for him, here with us he just mopes around. He's been so negative and listless these last few years, I don't know what to do with him. He also doesn't want to finish his apprenticeship, now that he has finally decided on something… after all, he is already 19. He is now seeing a psychologist, but that is also exhausting, because he presents himself differently to him than he does to others.
Pia:	Oh, dear, as they say, little children little worries, big children big worries. He's always been pretty introverted and focused on you. Well, I guess growing up isn't easy. Boys sometimes take longer to settle down.
Nicole:	I know…To the outside world they show up like grown-ups, but at home they are just so dependent and self-centered. They never ask how I feel. I mean, with the breakup, the move, and everything. I'm just so exhausted lately. I can't remember the last time I slept through the night and didn't already get up tired in the morning!
Pia:	Yes, it's high time that it's spring! When it's green outside everywhere, the world looks much more positive. Then you almost can't wait to get up!

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Nicole poured them a glass of rosé. “Now let’s have a drink first!”

Pia:	But really just one glass, I still have to drive. So here’s to us. To finally seeing each other again!
Nicole:	I have pistachios, you like them!
Pia:	Oh, wonderful – what a beautiful package!
Nicole:	A client gave it to me for my birthday. Actually the day I wanted to tell him I couldn’t see with him anymore, since he has gained so much weight. And then he brings a gift basket and thanks me for my great work! I couldn’t bring myself to say anything.

They both laughed.

Pia:	Let’s get back to your big boy. He still has his job, right? When will he finish his apprenticeship?
Nicole:	He’s just finishing up his first year now. Before that, all he did was internships in all those places. And it always took him a long time until he made the next attempt, although I had been constantly encouraging him.
Pia:	Maybe you need to tell him not to think he can quit his apprenticeship and then still stay home and just hang out.
Nicole:	We just had that! He was going to move in with his girlfriend. The next day his boss called and said he didn’t show up for work! I told him if he didn’t go back there, he couldn’t come home. I had discussed this with the psychologist and it actually worked. He then came back home, but he is so lacking in drive Pia, it makes me feel depressed myself just to look at the boy.
Pia:	Oh, you poor thing. But on the phone you talked about Daniel. What’s going on between you? I thought you’d split up for good! Are you seeing him again?
Nicole:	Not really, just for coffee sometimes. But he calls me regularly. On the one hand, I’m glad, but on the other hand, it upsets me. I mean, if he had finally closed the chapter, he wouldn’t say how he had hurt me, how he couldn’t do that to me, that we tried it again. He can’t talk to anyone like he talks to me, and confides in me about everything. Even about the women he’s been with since he moved out. The longer we talk, the more I think he wants to go back – and then he says he’s not coming back. So I don’t know where I stand with him at all.
Pia:	And you actually listen to this? Well, I can tell you where you stand with him, but I’m not sure you want to hear this….
Nicole:	Yes, I do. I just don’t know what else to do. Sometimes I think maybe I’m too old for him. He still has his life ahead of him – and I have no more strength for anything.
Pia:	Oh what nonsense, Daniel doesn’t want a woman his age – she would want children, and then he would have to take responsibility. That’s not for him. I’m telling you, he wants a woman to mother him. I told you years ago, he’s just selfish. Daniel likes to pass everything on to others, so that he’s never to blame for anything. You supported him so much. You took everything from him that he didn’t want to do. But that never ends! Men don’t eventually change and become what we want them to be. They stay the way they’ve always been – and why shouldn’t they, when it works so well for them? You worked your ass off, and he just did what he wanted. When you moved into the bigger apartment I first thought, aha, so he committed to you after all! And then I hear he’s moving out because he’s got a new girlfriend. After lying to you for months! What a jerk!

(*continued*)

(continued)

Nicole:	Well, I was always tired last year, all those worries around Markus, I didn't want to do anything anymore. When he was gone it was even more difficult, then I had no moment for myself. I only go to work and do my housework, and often I don't even manage that. I also never see friends anymore. I only talk about myself with my psychologist.
Pia:	Pia: What? You're seeing a psychologist?
Nicole:	I had a bit of a breakdown last autumn – I could barely stand up then, let alone work normally. Massaging is exhausting, and I don't just mean the physical part. The customers unload their problems, I have to listen to all that and then I'm supposed to say something encouraging. Also of course I didn't earn enough, it just didn't add up. Well, in the hospital they sent me to this psychologist. She advised me and also told me that I could get support from the social welfare office. We filled out all the forms together. Of course I want to get away from the welfare as soon as possible, but at the time this was the only solution. And at least I had the strength to get through the move, because we had to get out of the expensive flat of course.
Pia:	Oh, my goodness. I'm sorry to hear that. And you don't say a word! I could have come over for one day! You've had a lot on your mind lately. You're such a great woman, attractive, smart, practical, a great cook, you earn your own money. Daniel can't hold a candle to you. And then you're always worrying about how he's doing. I don't think he's worried about how you are. What does he do for you? He's crying to you about how hard his life is. He doesn't care how you are. It makes me so mad to see how this destroys you.
Nicole:	*cries.*
Pia:	You've always enjoyed your work! And no boss who only annoys you and orders you about. You have clients who bring you gift baskets!
Nicole:	*(Smiles)* That's true, I can do things my way, but that also takes a lot of energy. I have to deal with so many things, tax returns, the public health department, shopping at the wholesale market, there's so much to do. And I have to make sure the clients want to come back to me. They don't just come for a massage and lie there quietly, especially the women don't have anyone else to confide in. If I'm not feeling too well myself, I simply can't do it. It's already hard work physically, especially as people get ever plumper….
Pia:	Oh, sweetie. We really are survivors. This is all so exhausting, and no one ever worries about us. We'll be fine. Everyone's counting on that. And we'd better! But let's get back to Daniel. He can't help it. You have to get over the idea that he's going to come back and everything's will be fine! He's not happy with his life. First he thought he needed another woman, now he's tried it with several and realized he's still just as unhappy as before. You're not going to get a happy ending. Stay away from him. He's not good for you.
Nicole:	But I still have feelings for him! We were together for so long! He doesn't understand himself right now, and feels bad for me, so I can't stab him in the back. He always tells me that he misses me, and has said a few times that he would love to come back. Only when I need him to just listen to me, or when I tell him something with Markus, he gets upset right away and even hangs up on me sometimes. Well and then when I feel better he says, no, he wouldn't come back, I must have misunderstood. Then I am again completely at a loss.

(*continued*)

(continued)

Pia:	Poor you. Nicole, it's all his problem. You can't handle it, you're exhausted yourself! Daniel should see a psychologist. But he'll never do that.
Nicole:	No… I wasn't going to tell you either, but today I was so desperate – I was about to take pills when you called.
Pia:	Pills – so sleeping pills? Are you crazy? You can't do that. Sweetie, this isn't a good time for you right now, but it'll pass, the kids will be out of everything in a few years, then you'll have your life to yourself. Maybe you'll meet someone you like to be with again. But right now, you need to take care of yourself. Daniel's toxic for you right now. You can't spend hours talking to him. Then you realize you're still hung up on him, hoping he'll come back. But he's just dumped all his crap on you, and he'll be fine without you for a while. How are you going to get over that? You're rubbing it in, don't you see? I told you before, after he moved out – it hurts like crazy for six weeks, and then it gets better. But of course not if you rip it open again after four weeks! Then it never gets better….
Nicole:	*cries*
Pia:	Promise me you'll tell him to stop calling you, that you don't want to hear from him anymore.
Nicole:	But that's not true! If he were standing here now in front of the door with his suitcase, I would fall around his neck, in spite of everything.
Pia:	(S*ighs)* OK. Then at least tell him you won't talk to him again unless he decides to come back. And then you hang up the phone. Promise me. I want you to promise me one more thing. If you ever feel like you did today, you call me. Really, anytime. And if you don't feel like talking to me, you call your therapist, she's prepared for that. When she says you can reach her day or night, she means it. Let her help you.

9.2 Suicide Analysis: I Just Didn't See A Reason Behind It All Anymore

Ladislav Valach

The patient, who tried to overdose and then cut her wrist with a razor blade a week later, talks at length with a psychiatrist about her relationship crisis with her boyfriend, her worries with her 19-year-old son, and her living situation. She links her suicide attempt to some long-term and mid-term processes and concerns that need to be understood before one could comprehend her suicide attempt. The patient begins the narrative about her suicide attempt by stating that she is self-sufficient. Later, her concerns about her work activities also play an important role for various reasons.

9.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

9.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

A 11-year relationship between the woman and her boyfriend ("relationship to boyfriend") was terminated by him and he moved out of the shared apartment within a week. The patient wanted to maintain this relationship. Subsequently, they talked to each other on the

phone for many weeks and hurt each other ("breakup with boyfriend"). The patient wished that he would come back and that he would not keep hurting her with his phone calls. The patient was also very worried about her older son ("relationship with older son"), who was already unhappy about some things for a long time. Like all mothers, the patient wanted her son to be happy and content, and to look to the future with confidence. She also tried very hard to achieve this. The patient's "drinking problem" also played a role in her suicide attempt, which she feels she has had well under control recently. She is working on reducing her alcohol consumption. During her first suicide attempt, an acquaintance called, who then also came to her home. Further, the patient reported that she had many friends and acquaintances ("relationships with friends and acquaintances"). It was the patient's concern to treat her friends courteously and kindly. As a single parent, the patient was always concerned about her "work activity" and suffered from having too little energy for her work during her crisis. The woman was very concerned about achieving and maintaining her financial self-sufficiency. She always wanted to do the best she could in her work. She recently completed "additional training" and this opened up additional job opportunities. Her "family", which is currently disintegrating, to her regret, is a very important concern to the patient. The "relationship with her father" is difficult at the moment. He had burdened her with suicide threats in childhood and currently wants to use her for driving services, for which the patient has too little time and desire. The patient would like to distance herself from her father, who frightened her very much in childhood and now also claims her and her time for himself. The patient has been going to "psychotherapy" for some time, a concern that means a lot to her. She also dealt with the thought of "dying" for some time. When she broke up with her long-term boyfriend in her 20 s to live with the love of her life and the boyfriend then threatened her with a gun, the patient overdosed. Several years later, when her husband left her with young children, the patient again entertained the thought of suicide, but did not attempt it because she did not want to leave the young children alone.

Long-Term Concerns

The patient thought several times in her life about "dying" and had already tried this twice. Of course, she also fought for her "life" and was able to postpone her suicidal thoughts several times. Her experience of "wanting to die" was closely linked to her "relationship with her father", who often expressed his suicidal intentions and upset the patient as a child: "My father just again and again has his suicide attempts. He was always threatening us that he was going to kill himself. Even as a little… He was just always threatening. We all suffered a lot from that." Closely related to her concerns about "living" or "dying" was her concern about "looking to her family," or keeping them together. When her husband left her, she struggled through the crisis thinking she could not leave her young children alone. But when her boyfriend moved out of the apartment they shared after a 11-year relationship and her son also wanted to move out, the patient saw her family falling apart. She intended to overdose on medication and later slit her wrists. The "relationship with her boyfriend" was an important long-term concern of hers, but it was very likely to be affected

by other concerns, such as "worries about her sons", "alcohol problems", "financial worries", or the failure of these plans, which she feared. The concern "to die" became more important than the concern "to live" because the patient's family fell apart under unfortunate circumstances. All the important ingredients of the good life showed themselves, in her eyes, to be threatened. The boyfriend left her, the son is unhappy and moves in with his girlfriend, the patient's financial security is threatened, and she feels too weak to work. Her concern to live was not paramount as the most important thing to all other concerns, but she saw it as dependent on other concerns. The unconditional of life as the goal of her actions was lost in this crisis. The very important concern of the "meaning of life" no longer seemed attainable to her.

Medium-Term Concerns – "Projects"

The most important medium-term concern that the patient describes in connection with her suicide attempt is the "separation from her boyfriend" that has already lasted for three quarters of a year and that she would like to end by getting together again. The problem is not only that he has moved out of the apartment they shared, but that he keeps calling and letting the patient share in his feelings without wanting to resume the relationship: "He used to call me and play mind games with me. He used to cry on the phone. But he still never wanted to come back." The patient wished that he would stay with her and if not, that he would leave her alone. Another important relationship that she currently suffers because of, and felt was neglected by her boyfriend is "living with her older son." For a long time, she worried and worried that her son was unhappy at his job and depressed, "So I invested a lot of time in my son. And that's when my ex-boyfriend suddenly felt I wasn't paying enough attention to him." On top of that, lately her son has been spending weekends with his girlfriend's family and now he's also packing his bags and moving out ("the son is moving out"). We can very well imagine that the patient would come to terms with her son becoming independent, but that she would like this to happen under different circumstances. She said that her son should be happy with his work, that he should be confident and optimistic about his days, and that he should spend occasional weekends at the patient's home with his girlfriend. In addressing her "drinking problem," the woman felt she was at a stage where she was "in control" of her "drinking." She only drank enough to fall asleep, she said. Immediately before her suicide attempt, however, she was drinking excessively again. The crisis in her relationship with her boyfriend was affecting the patient's "work problems" and her health ("nervous breakdown"): "I couldn't work properly anymore either. I then also had a nervous breakdown in the autumn. It just all came at once." The patient then wanted to solve all these problems in one project: "And then I simply had the desire on Good Friday to be able to draw a line under everything. I just had the feeling that I had to do something. Otherwise I just didn't see any other way out. It's been almost a year since the whole breakup. And I just can't get over it. I'm just still in the same place. For me, it was a tremendous burden. I was no longer able to do my job at that point." This project was then the patient's suicide attempt. One concern that also failed in her eyes was her "financial hardships to resolve": "We lived in a more expensive apartment

for about a year and a half. We thought at the time that we could afford it because we were together. We always lived together. But then, of course, I had to move back on the first of the month. That then hit me back again financially. When you're two people sharing all the expenses… with him, that's how I meandered along. The money was always just enough. But now, of course, there's not enough money at all. So now I'm also dependent on the welfare office. That creates even more problems for me. I also wanted to get away from this dependency as soon as possible. But it's just not working." This statement includes other medium-term projects: "Moving house" and "Overcoming dependence on the social welfare office". The patient was aware of her stress and overwhelm at this stage of her life and was receiving "psychotherapeutic treatment" at the time of her suicide attempt, again a goal-directed activity in a medium term time frame. All of these medium-term projects and concerns are to be understood as part of the patient's broader, longer-term efforts and concerns, and the patient also describes them in this way. Likewise, all of her actions, and especially her suicidal action, are to be seen as part of these medium-term concerns or projects. The patient reports her suicide as an action that plays an important role for the medium- and long-term concerns and is to be understood from these.

Summary

1. In her narrative, the patient describes a number of different long-term and mid-term concerns that she sees as closely related to her suicide attempts.
2. It is mainly her long-standing relationship with her boyfriend and partner. For several years she has also been preoccupied with how to improve the life of her older son. For several years she has been dealing with her alcohol problem. Very important to her is her work activity, which secures her family's livelihood. She therefore invests in additional training to improve her earning potential. This further includes her preoccupation with financial worries, which have worsened since her breakup with her boyfriend. Many of these concerns attest to other important goal setting issues affecting her family. She is still preoccupied with her relationship with her father, which was already difficult when she was young. The patient still takes a defensive stance here. Finally, she also tells of her repeated desire to die, then of her will to live, and last but not least of her effort to find the meaning of life. These concerns must be known in order to understand her suicide attempts.
3. Among the medium-term concerns, she counts above all the overcoming of the separation from her boyfriend, who left the shared apartment. Her older son also wants to leave the shared flat, which the patient has to deal with first. She is also in the process of coming to grips with her alcohol problem and managing her health issues. Among her positive concerns she counts her relationships with friends and acquaintances, as well as her psychotherapeutic treatment. Currently, she is preoccupied with moving house, her work problems and her dependence on social services, which she wants to overcome.

9.2.1.2 Actions of Suicide in Suicide and Other Projects

The young doctor who had the conversation with the patient asked at the beginning: "…if you could tell me how it could come so far from your point of view…". That is, she did not ask "what happened" or "what did you do", but inquired about a broader process. And so the patient recounts her suicide project.

This includes, in their understanding:

- Her work: "It's not that easy. I'm self-employed. By that I mean I work independently."
- Her family: "I have two sons. One is 19 and the other is 17. So that means they are both almost grown up."
- Her partnership: "I've been divorced for almost 12 years. For 11 years… For 11 years I had a boyfriend. Everything went quite well – even with the children together."
- Her crisis in the partnership: "And then suddenly last summer he said that it could no longer go on like this. We'd already had a few crises. The working hours were totally different, first of all. He worked weekends and evenings and I worked more during the week in the daytime."
- Her concern for her older son: "I also have very big problems with the older boy. He has been depressed for some time. He is also in treatment with a psychologist. He just doesn't know what he wants. He's just totally lost all his self-esteem."
- The mutual influence of problem-solving concerns: "I therefore invested a lot of time in my son. And that's when my ex-boyfriend suddenly felt that I wasn't paying enough attention to him. He told me that he felt like a third wheel and that he just didn't want that now."
- Her partner's different life plans: "He still wants to achieve so much in life. He wanted to travel and so much more. He then simply said that he wouldn't be able to do all that if he continued to stay with us."
- Partner's new relationship: "At that time, my feminine intuition also told me that there was another woman involved. But he denied it over and over again. But I found out later that I was right. That hit me very hard. He just lied to me for a month or two."
- Separation from partner: "I couldn't accept that he just moved out of my place within a week – not after an 11-year relationship. Just off, done, finished…"
- Phone calls and conversations with partner: "But it didn't end there. He used to call me and play mind games with me. He was always crying on the phone. But he still never wanted to come back. He had just hurt me far too much to do that to me now. He also said that he couldn't understand at all how he could have made that mistake once. Then it was funny too… Every time I got a little better… He always gave me hope. I always had the feeling that one day he would still come back. But every time I asked him about it he told me that he couldn't because he hurt me way too much. He simply said that he couldn't and didn't want to anymore. The thing with the other woman was then only a very short thing when he had moved out. There was then also no more. Since October he has a new girlfriend again. But that doesn't work well either. He just can't be alone.

And then he calls me again and again. I call him sometimes too. That's how we make each other… I don't know."

- Psychological consequences of the problems: "I slowly but surely had the feeling that I was going to break. I couldn't work properly any more either. Then I also had a nervous breakdown in the fall. Everything just came at once. On top of that, there were all the recent problems with the eldest son."

Suicide as a solution to problems: "And on Good Friday I simply had the desire to draw a line under everything. I just felt that I had to do something. Otherwise, I just didn't see any other way out."

Layout of the Issues in Major Concerns About Suicide

- "It's been almost a year since the whole **breakup**. And I just can't get over it. I'm just still the same. For me, it's been a tremendous burden."
- "I was no longer able to perform my **job** at that point. I am a masseuse. You need a lot of strength and energy to do that. But I just didn't have that anymore... I can't get myself up at the moment to be able to work more. I'm always like spinning in circles. I just don't see a way out."
- "On top of that, we had to **move.** We lived in a more expensive apartment for about a year and a half. We thought at the time that since we were together, we could afford it. We always lived together. But then, of course, I had to move back to the first of the month."
- "That then hit me back **financially.** When you're two people sharing all the expenses... With him, that's how I meandered through. The money was always just enough. But now, of course, there's not enough money at the back."
- "So now I'm also dependent on the **welfare office.** That creates even more problems for me. I also wanted to get off this dependency as soon as possible. But it's just not working."
- "I also have a lot of trouble with the **son.** He would like to hang up his apprenticeship. One evening when I came home his suitcases were packed and he was no longer there. The next morning I got a phone call. His employer asked me where he was. He hadn't shown up at work."

Cognition P: "I then just felt like I couldn't take it all anymore. There was just so much coming at once."

After this list of major concerns in her current life and the problems that are currently piling up, the patient describes her actions with the corresponding thoughts and feelings during her suicide attempts.

She starts with her second suicide attempt, because that's where she began the suicidal action, whereas the first one was just the intention and the preparatory steps.

The Day Before the Second Suicide Attempt; Patient (P), Boyfriend (F):

Cognition P: Then there was also Good Friday….
Cognition P: He (F) has now gone overseas for three weeks with an acquaintance.
Cognition P (Action F): He said before that he would love to go overseas with me, that he would love to come back to me.
Cognition P (Action F): He also said that he would miss me and that the story with the other woman happened because he was fooling himself. Then before he….

The Last Conversation Before the Second Suicide Attempt: Joint Action; Patient (P), Friend (F):

Cognition P: On Good Friday, we talked on the phone again.
Action P: That's when I asked him his point of view.
Action P: I told him that sometimes I just didn't know where I stood anymore.
Joint Action F, P: Then he told me that it was all clear to him from the beginning. He had always told me that he would not come back.
Emotion P: I was very hurt by that.
Cognition P (Action F): He portrayed me as inventing things which are not true at all.
Action P: I then simply told him that I knew he had said that once.
Cognition P: Whenever we talk together, then… We can't be normal with each other at all.
Cognition P (Action F): First he yells at me and then he always hangs up the phone. But then he calls me right back to apologize. After that he cries again ….
Cognition P: It's just a weird back and forth.
Cognition P: I just can't take this anymore. I can't stand him, the whole story with my son and on top of that my work.
Cognition P: I just didn't know where I stood anymore.
Emotion P: I just didn't see the reason behind it all anymore.

Second Suicide Attempt; Patient (P):

Cognition P: That was the following Saturday. I was alone then too.

Evening Before the Second Suicide Attempt; Patient (P), Boyfriend (F):

Joint Action P, F: On Good Friday before, we had this big argument.
Cognition P: I couldn't see the point of anything anymore.
Action P: I also spoke to him on the phone to leave me alone, that I just couldn't keep driving like this.
Action P: I told him that I couldn't take it anymore, that I really wanted to draw a line under all this. I wanted to make a new start.
Action P: I just told him not to call me anymore, that I didn't want to see him anymore – just nothing. Otherwise I just can't get away from him.
Action P: That's when I said some hurtful things to make it hit him and stay.

Action P: And then I told him that we couldn't stay good friends… It just doesn't work, it can't. As long as I still have so many feelings for him, I just can't.
Action P: I told him that he just couldn't ask me to talk on the phone during the week, meet for coffee, chat together, but then he goes to the other girl's house on the weekend and I don't hear from him.
Action P: I told him that it would cause me too much pain.
Action P: Therefore, I also told him quite clearly that I wanted to break off contact with him.
Cognition P: After that, that Saturday was….
Cognition P: … And then I thought … I didn't hear from him now.

Disappointed Hope as the Reason for the Second Suicidal Action; Patient (P):
Cognition P: I just still had hope that he would come back to me.
Cognition P: And on that Friday, I just realized that it was now final. I just knew that I wasn't going to go through with this anymore.
Cognition P: Yeah… Probably that's the point. I still had hope that it would still go again, that he would come back.

Telephone Conversations; Patient (P), Friend (F):
Cognition P: Saturday evening. I don't even know exactly now – I don't know exactly when this was….
Action P: I spoke to him on the tape for the first time as early as Friday night.
Action P: But then I texted him a second time regarding "being good friends" on the tape.
Action P: I simply wrote to him – … I simply told him that the wounds which he had inflicted on me, that they would scar already once.
Action P: But I also told him that I could never forget all this anyway. That's why all this doesn't work at all. That's why it would be best if we broke off contact now.
Cognition P: It's the first time I've said it so clearly. Although I have said before that he should never call me again.
Action F: He then kept that up for a week.
Action F: But then he called me again and howled like a castle dog and said he couldn't do it.
Action P: I then asked him what he actually wanted.
Cognition P: I told him enough times that I still loved him and that I was ready for a fresh start.
Cognition F: But he doesn't want to – he can't and he doesn't want to.
Cognition F: He's also mentally distressed.
Cognition F: He's not quite over the fact that he could do all that to me.
Cognition P (Feeling F): That hurts him too.
Cognition F: That's also why he can't come back.
Cognition P (Feeling F): He is afraid that I will never forget this, that I will hold this against him for the rest of my life.
Cognition P: Whether that will be the case, I don't know now.

Action F: He also took out a life insurance policy in my favor. He did that in case something happened to him. We were together for a long time.
Action P: Therefore, I also told him that he could sign this insurance over to the other woman.
Action P: I told him that he was just dead to me, that I would rather die than take his money.
Cognition P: Yes. Then, nevertheless, came this final.
Action P: I already needed hurtful words that I knew were going to offend him.
Action F – Feeling P: He just inflicted so much pain on me….
Cognition P: I don't know, but I could never do something like that with a fellow human being.
Cognition P: I also find that when someone is gone, that it's just over – done.
Cognition P: But I could never play such a game of cat and mouse with this person for ¾ year.

Friend Keeps Backdoor Open; Patient (P), Friend (F):
Action F: He always kept a "back door" open.
Action F: When he had sorrows and worries, when he was not well, he would call me again and cry into the phone.
Action P: I then spoke to him again and tried to calm him down.
Action P: But in return, the next time I called him when I was feeling bad,
Action F: then he just yelled at me and hung up the phone. That's just how it always went.
Cognition P: Yes. When I was well again, he gave me hope.
Action P: But every time I'd call him on it.
Action F: He said that he never said that, that he would never come back to me.
Action F: He told me that I should finally realize that he didn't love me anymore and that it was just over once and for all.
Feeling P: At this moment I was then in each case completely on the ground again.
Cognition P: And he played these games a few times.
Cognition P: I just couldn't take it all anymore. I told myself that if I didn't react like this now, that I would never get out of all this.
Cognition P: He just has to understand me. I have to protect myself in this way. If I don't do anything, then all this will go on for months.
Cognition P: I just don't want this anymore.
Cognition P: I want to finally have a bit of joy in my life again. I also want to be able to enjoy my work again, to achieve more.
Cognition P: I just thought that now he will never call me again.
Cognition P: But still, it wasn't easy for me. I realized that it was now final.
Cognition P: In addition, both boys had flown out.

Letting Go of the Children; Patient (P):
Cognition P: Now I've just been advocating all these years -- for the kids, too.

--- Cognition P: I have provided for them so that they are well.
--- Cognition P: I tried to do my best despite the divorce and all.
Cognition P: The father never showed his face again.
Cognition P: He didn't care about the kids at all.
Cognition P: The boys don't ask me if I'm alone on the weekend either.
Cognition P: That's their right, too, of course.

Older Son's Crisis; Patient (P):

Cognition P: On top of that, there were the problems with the older son. He just wants to quit everything. And then always look at this head….

Cognition P (son): In the morning, when he gets up, he hangs his head. In the evening, when he comes home, he hangs his head again. He no longer looks forward to anything. He has no more hobbies. On weekends, he's just gone from Friday night to … sometimes I still see him come home on Sunday night. Or otherwise I don't see him then until Monday night when he gets home from work. Somehow I don't think that's okay either.

The Family Crisis; Patient (P):

Cognition P (Family): There is just nothing left of our family. We never sit together at a table on the weekend anymore and eat the well-cooked meal… It's just every man for himself. Everything is just like that. This is also another problem that is bothering me.

Action P: I also told them that they didn't always have to be with her the whole weekend, that they could also spend a day with us. But I don't know….
-- Emotion P: But then so much comes up in moments like that.
-- Feeling P: I had the feeling that no one needed me anymore anyway, that at my age life was just over.
-- Feeling P: Then I felt… I don't know.

Cognition P: I just, like I said, didn't see the point behind it all anymore. I didn't know why I should go on.

Feeling P: I then felt alone. I felt like just nobody needed me. Then I then….

Alcohol Problem; Patient (P):

-- I had another drinking problem once in between.
--- Mrs. L. (psychotherapist) knows that.
-- I've had a relatively good handle on myself lately, though.
--- I drank nothing more during the day.
--- And in the evening I drank only so much that I could fall asleep well, that I could switch off.
-- But that doesn't help.
--- The next day you are confronted with everything all over again.
-- I've had a really good handle on myself lately.

Action P: But then I opened the bottle and….
Feeling P: Then the great misery came upon me.
Emotion P: I started to cry.
Cognition P: At this moment you are just very little far from it….
Cognition P: I can hardly describe this feeling.
Feeling P: One feels abandoned at such a moment.
-- Cognition P: One does not know how to proceed now.

Action Before Second Suicide; Patient (P):
Action P: Then I started drinking alcohol.
Action P: I already drank a whole bottle. A bottle of rosé – wine.
Cognition P: For me, it doesn't take much for me to feel it. I just didn't see the point behind it all anymore.
Cognition P: With the drinking, it all came back to me.
Cognition P: At that moment, the children were no longer there either.
Feeling P: I just felt like nobody needed me.
Cognition P: I asked myself about the meaning of my existence.
Action P: Then I went into the bathroom.
Cognition P: I was wondering whether to do this or not.
Cognition P: At this moment, the inhibition threshold that you still have to cross is so small.
Cognition P: But I also have to say that if I didn't drink alcohol, that I wouldn't have done it. That's the same as with drugs and tablets. You then reach a certain level where everything seems indifferent to you.

Second Suicide Action; Patient (P), Son (S), His Girlfriend (Fr):
Cognition P: But then a week later… I don't know either….
Action P: I didn't do anything … I cut myself with a razor blade. I didn't take any pills.
Cognition P: You would have to prepare that… You would have to collect….
Cognition P: Yes, that one would then have enough for the deed.
Cognition P: That was already spontaneous. It was like a knee-jerk reaction. I didn't kind of … I didn't think about it at all – even during the day. That came all of a sudden. At that moment, everything just came at me. It all came crashing down on me.
Cognition P: I no longer saw any way out, any sense in all of this….
Action P: Yeah – so then I just went into the bathroom to get a razor blade.
Action P: Then I practiced in the kitchen.
Cognition P: But it didn't go the way I wanted. It was kind of blunt.
Action P: … cut, here on the wrist. But it has to be a very deep cut that you die. So there I was practicing in the kitchen.
Cognition P: It was already bleeding a lot, too.

The Critical Action Step of the Second Suicide Action; Patient (P), Son (S), Girlfriend (Fr):

Cognition P: When this blade just wasn't cutting I also wondered what I was going to do here now. I wondered if I would now have to go get a new one that would cut better. In the bathroom I had more blades I had just taken the blade out of the razor.

Action S, Fr: And the moment I thought about it, the kids came in the door.

Cognition P: But they told me they wouldn't be coming home. They told me that they would sleep at her house.

Cognition P: That was about 12:30 at night.

Cognition S, Fr: That almost gave them both the punch.

The Time After the Interrupted Second Suicide Action; Patient (P), Son (S), His Girlfriend (Fr):

Emotion P: I started crying.

Action P: I asked them why they were coming home already. They had said that they would not come home at all.

Feeling S: The son was very firmly frightened.

Action Fr: She then bandaged my wrist.

Joint Action P, S, Fr: Then the three of us talked about all this.

Cognition P: I have to say that my son's girlfriend is quite the speedy girl.

Action P: I then told her that I just feel really alone sometimes.

Cognition P: I'm not used to being alone either. I have never been alone in my life. I still have my two children. But they are more or less no longer at home.

The Conversation with Son and His Girlfriend After the Second Suicide Attempt; Patient (P), Son (S), Girlfriend (Fr):

Feeling P: When they came home – At the moment I was angry.

Cognition P: They came even though they said they wouldn't.

Action P: I then snapped at them why they had come now.

Action Son: He just replied to me that they were just here now.

Action P: Then I said that I would see that.

Action P: I then asked them why they didn't stay.

Emotion P: Then I just cried.

Action P: I've been telling you all along….

Feeling P: Now I'm glad they came at this time.

Cognition P: I just thought afterwards… I'm going to give them all grief if I die. I don't know.

Action son, girlfriend: They also kept telling me at that moment that they needed me, that I couldn't just leave. The two of them then also stayed with me.

Action S, Fr: They just stayed at our house that night – his girlfriend and him.

Action P: (After) she bandaged my wrist I went to sleep in my bed.

Suicidal Intent to First Suicide Attempt One Week Ago; Patient (P):

Cognition P: Last Saturday, eight days ago, I wanted to take sleeping pills.

Cognition P: These are very strong. On weekends I am usually alone too. The sons are no longer at home.

Cognition P: The older one has a girlfriend. So he usually stays right with her to sleep.

Cognition P: With us, family life is simply disrupted.

Emotion P: That hurts me when we never sit together at the table anymore, never speak all together.

Cognition P: He'd rather go to her house then. There is something going on there. There is also a father at home. His girlfriend also has two younger brothers. It's just different there. He finds a change in it. That is important for him, because otherwise he is not well together.

Cognition P: And the younger boy is always out with his friends, too.

Cognition P: That's why I wanted to have a nice evening watching TV.

Emotion P: But then it all came crashing down on me….

Action P, Cognition P: (suicide attempt): I already had the pills in my hand when the phone rang.

Conversation with an acquaintance; acquaintance (K), patient (P):

Cognition P: It was an acquaintance who drove past B. on her way home from Z. The person in question was a woman.

Action K: She asked me about my well-being.

Action P: I said I wasn't feeling so well.

Action K: That's when she told me to wait and that she'd be right over. She is otherwise really….

Action P: I told her then.

Action K: She told me that I could always call her unabashedly in such moments.

Cognition P: I really have a lot of people who know me. I have a lot of good friends and acquaintances. But I just can't do that sometimes either. I can't always just phone someone else and say that I'm feeling bad. At the moment I'm just feeling bad all the time. I think that I would get on my fellow men's nerves with that.

Cognition P: The boys also can't stand it with time that I don't know in or out. I already pull myself together from time to time. So I just can't let myself go the way I would like to. On the one hand there are the children and on the other hand also the work.

Cognition P: That's where I just have to go and be present. I have to deal with the customers, I have to be friendly with them. The customers can't have someone standing next to their shoes. If that's the case, they just don't come anymore. That's why I always just have to put something in front of everyone. In between then everything just flies together. I don't know anymore….

Aborting the first suicidal action:

Action K: The acquaintance then came by. She called at that time.
Cognition P: She was with me and we still had a really nice time together.
Action K: So at 11:00 she left.
Action P: I then called her and told her that I was glad she had come for such and such a reason.
Action K: She also told me that she had noticed on the phone that something was not good with me. That was also the reason why she had come.

The Feeling of "being Abandoned" in the Patient's Life; Patient (P):
Cognition P (feeling abandoned): Ever since I've been in the world, I just keep getting abandoned by everyone. First my ex-husband left me, then my ex-boyfriend. And now my oldest son has also packed his bags and wants to leave me. He now blames me for not raising him enough to be independent. It's just my fault that he's like this now.

Conversation with Therapist; Patient (P), Psychotherapist (Ps):
Action P: The following week I had to go to Mrs. L.. I have been in talk therapy with her since January.
Action Ps: And she then asked me if you couldn't record this event here….
Action P: I then told her that was fine.
Action Ps: She also told me that I could call her anytime – that I could call the clinic day or night.
Cognition P: But in such moments you don't even think about it. In such moments you want to end your life. You certainly don't call someone who wants to prevent the deed.
Cognition P: Yes. I really wanted to die. I really felt at that moment that I wanted to die now and nothing more… I didn't want to know, hear, see, … I just couldn't anymore.
Pain P: The arm still hurts.

Suicidal Ideation in Patient's Life; Patient (P):
Cognition P: It's been going through my head a few times. Whenever I was feeling so bad, I wished I didn't have to live anymore. Life just didn't make any sense to me at such moments.
Cognition P: I had those thoughts on and off all summer. I wouldn't have done it at the time though. But I just always felt like my life had no meaning anymore.

History of Other Suicidal Actions; Patient (P):

Divorce:
Cognition P (Memory P): That was during my divorce. I had a nervous breakdown then too.

Breakup with First Boyfriend; Patient (P):
Cognition P (Memory P): But that was … With my first boyfriend – I was in hospital at the time. That was with my first boyfriend I had for three years.

I was 19 years old. We were together for three years.
Action P: Then I met my ex-husband.
Cognition P: From that moment on, I just knew that I didn't want the other person now. That was simply love at first sight. I just thought that it had to be this one and no other.
Action P: I then told my boyfriend at the time.
Cognition P: This one was a very irascible person. He went as far as slapping in the face.
Cognition P: I wondered for some time if this was now the life I wanted to live. – Whether I now wanted to live a lifetime with this person…
Cognition P: And I knew for some time that it just couldn't be.
Cognition P: But I just couldn't bring myself to leave and walk away from him.
Cognition P: But then when I met my ex-husband, that's when I had the courage to leave him.
Cognition P: That's still often the case. That was all so….
Action Other: All told me why I now left this one. Everyone told me that I should go back to him, that this one had a good job. Everybody spoke to me. We had been together for three years by then.
Cognition P: But I just knew I didn't want that. He then threatened me as well. I wanted to go get my things in our shared apartment at that time. And at that moment he threatened me with a gun – or I don't remember. He wanted to blackmail me.
Cognition P: But I was sure that if I couldn't have the other one, that I would never go back to this one. I would rather die.
Action P: I was taking pills at the time.
Doctors' action: Then they pumped out my stomach. I was then sent to the hospital. That's right…. ◄

I was about 21 years old.

Marital Crisis and Separation; Patient (P):
Cognition P: Yes. So it's always about the theme of leaving and being left.
Emotion P: When my ex-husband left me, I also felt very bad.
Cognition P: This one was an alcoholic. I always felt that I could help him. But I still couldn't. But at that time the children were so young. I never had the thought of suicide. I just couldn't. The older son was 7 and the younger 5 when we finally divorced. But there had already been a crisis in the family for three years.
Cognition P: The kids kept me from doing the deed. I just knew that was my job. I wanted these children – they were already unexpected. But I always wanted to have children in my life.

Family of Origin; Patient (P):
Cognition P (Childhood): We are five siblings – four girls and one boy.

Father and His Suicide Threats:

Cognition P: My father is an impossible guy. That's just it. My father just again and again had his suicide attempts… He was always threatening us that he was going to kill himself. Even when we were little… He was just always threatening. We all suffered a lot from it. But he never did anything. He never attempted suicide. He just threatened to shoot himself, hang himself, … That didn't stop until today. That's when we kids used to get into a huge mess. He's just a very big egoist. He only thinks about himself and nobody else. And that's still the case today. Of course he has a hard life with his illness. He hasn't been able to work for a long time. He had to amputate his leg. He also has problems with his hip joint and on top of that he has high sugar levels. He now also comes here to the hospital two to three times a week for dialysis. It's just….

Sister and Her Relationship with Her Father:

Cognition P: My sister, that's even more interesting. She suffers even more from him. She has… I don't know. She married a man to be able to escape at home. It was like an escape. But she married a man ten years older. That's almost like a substitute. But that didn't work either….

Relationship with Father and the Time After the Suicide Attempt More than 20 Years Ago:

Cognition P: This issue has haunted me all my life. It's the same way. I can still remember. When I was in the hospital after taking pills… I can still see that. Who was standing upstairs by my bed when I woke up? It was my father. And the first thing he did was berate me at the top of his lungs. So I closed my eyes and told him that I just didn't want to hear anything more from him.

Family Takes up an Inordinate Amount of My Time:

Cognition P: I have no contact with him now either at the moment. I just don't feel like it. It's also a matter of always taking him back and forth – to dialysis and back again. Four years ago I had the leg in a cast. He was in the hospital then too. I used to go visit him at that time, drive him around, take care of the mother… And this summer, it all started over again. He had to go back to the hospital. Then they felt that now I had time, since my boyfriend had left me… That's when it all started all over again. They just wanted to put me back in it. I should have fetched the mother in the morning and driven her to the father in the hospital. In the evening at 5 p.m. I was supposed to get her again and drive her home. But there I simply refused. I told them that I just wasn't going to do it anymore. I told them that I had four other siblings. Let them do something for once.

New Conversations with Friend; Patient (P), Friend (F), Acquaintance (K):

Cognition P: I'm not doing bad. Just the thing with the son… Last Monday I just did another bit… That was another thing… That Saturday I did it, I knew that my former boyfriend was going to fly off overseas the following Wednesday. It told me that he was

going to call me before that to say goodbye. That was before I told him I didn't want any more contact with him. But I told him that wasn't necessary, that he never had to call me again. Then he called a friend of mine to say goodbye. He wasn't allowed to call me anymore. He left on Wednesday. But on Friday he called my friend again. But she didn't hear the phone, so she didn't pick it up. On Sunday he called her again. She then asked him how he was doing. He then told her that he was not doing so well. She then asked him why. He told her that he was missing someone badly. She asked him what he was longing for. After all, he was overseas, having sun… and we in Switzerland have such bad weather. Then she asked him if he missed me. He said yes and started crying. I just thought it couldn't be true. He left me a message on the answering machine that same evening. He told me that I just couldn't do it that way, that we couldn't break up like that. He wanted to know how things were going with me. I have just finished a training and now I give some lessons in the fitness center. I had my first lesson on Sunday. He then told me that he would call me again. At that point I just didn't know what to say. This is easy for me… Monday at noon the phone went off and the number wasn't on the screen. So I picked it up and it was him again. I wanted to hang up right at the beginning, but couldn't. He told me that he was so homesick. I told him that he was on holiday for three weeks – it couldn't be that he was already homesick. Then he told me that the words that I had spoken on the answering machine and written to him had hit him to the core. Then I told him that this was what I had intended. I now simply wanted to break off this contact.

Action P: I told him he couldn't make up his mind.

Action P: I told him that he had to make a definite decision by the end of April.

Action P: I also told him that if I didn't hear anything more from him now, that it was clear to me and that I then also never wanted to hear anything more from him.

Action F: But he told me that I already made the decision for him last Friday.

Action P: I then said that it was therefore probably better to break off contact.

Action F: He was going to disagree.

Action P: But I told him that I just had to do it that way, that if I didn't, I was going to break.

Present/Future:

Cognition P: I also felt like I should go somewhere for two weeks now to get away from everything. I have a feeling that this would do me good. I don't know – to some spa… But of course I also have to see who will pay for all this.

Cognition P: I just have to say that I'm not doing too bad right now.

Cognition P: But I just don't know what it's going to be like when he's back in Switzerland. I just tell myself that I will hang up the phone. But how I will react in the specific case, I don't know. ◄

Summary

1. Within the long-term and medium-term concerns and goals, the patient describes a number of different actions in different areas of action and medium-term projects.
2. She then describes the actions on the day before the second suicide attempt, the last conversation before the second suicide attempt, joint actions in the second suicide attempt, actions on the evening before the second suicide attempt, she describes her disappointed hope as the reason for the second suicide action, describes telephone conversations with her boyfriend, and describes how her boyfriend keeps back doors open, lists actions and thoughts about letting go of the children, describes actions during the crisis of the older son, actions that illustrate the crisis of the family, describes further details of the actions before and during the second suicide attempt and the time after the second suicide attempt, as well as the actions of the conversation after the suicide attempt. She describes the suicidal intent for the first suicide attempt a week before the second suicide attempt, as well as the conversation with her acquaintance that led to the abandonment of the first suicide attempt.
3. She tells about her feeling of "being abandoned" in her life and the corresponding actions, her conversation with her psychotherapist, the suicidal thoughts and actions in her life, her divorce many years ago and the separation from her first boyfriend, as well as her marriage crisis. She then depicts her family of origin in some actions, her sister and her relationship with her father, and the actions after her suicide attempt more than 20 years ago.
4. Lastly, the patient talks about the actions of her overuse by her family, her recent conversations with the boyfriend, and expresses herself about her current situation and future plans.

9.2.2 Problems of Action Organization

As was already evident in the discussion of the woman's long-term concerns, the concern to "live" was only of secondary importance and was linked to certain conditions, such as "the partnership must be right", "the family must be kept together", "the sons should be happy", etc. It is conceivable that the patient learned from her father that suicide was a solution option for various problems. And so an ultimate goal of any person, "to live," became only a means to an end; there the alternative of dying presented itself as a problem-solving option. This is a problem of action organization in long-term processes. However, the patient did not use this option (to die) only as a solution of existential problems, such as "my life is and will not be good any more and so I am ending it", but she tries to take her life in order to solve certain short-term problems, such as "I feel abandoned, my sons (are) leaving home" (a fact that all parents have to accept, and which is very difficult to bear only in its actuality), or as well as "my young boyfriend left me and I feel lonely",

or “there are financial problems”, etc. This confusion in the order of long and medium term goals and concerns is surprising in this woman. For she tells how, as a young girl, she gave up a long relationship to follow the love of her life, how she prevailed despite fierce opposition from her partner at the time, how she then started and carried through a family despite her husband’s alcoholism, how, when he left her, she then established an independent professional existence, entered into a new relationship and maintained it for 11 years. All of this indicates that the woman is well able to cope with the major problems of independent living and is quite self-determined. However, she recounts how she resorted to a medication overdose when her first partner resisted and would not let her go. When she was then left alone by her husband with two small children, she experienced this as a severe existential crisis in which she was only not suicidal because she did not want to leave her small children. Then when her boyfriend of 11 years ended the relationship, she tried a suicide action again. So there are certain problem areas where the patient gives up her order of actions, or it is not accessible to her. This does not occur during cool deliberation and problem-solving, but takes place in an emotionality (infatuation in the first case, feelings of loneliness in the present crisis) or in a weakening of decision rationality through alcohol consumption. We can surmise that this has much to do with the patient’s experience with her father, who, according to her, frequently threatened suicide. The patient self-reported how this messed her up. We can understand this “confusion” in the way that the children, during the time when they were learning their problem-solving skills and the ability to make responsible decisions, were unsettled in their rational decision-making ability by this alternative action “suicide” by an emotionally relevant person – the father.

The patient describes a series of crises – concerns that are not going according to her wishes – then states “there is no point”, becomes absorbed in her sense of despair and attempts to end her life. This sequence of actions or action steps is not uncommon in suicide processes. Yet it demonstrates a profound disruption in the organization of action. Instead of taking on a problem, setting as her goal its solution, preparing herself for the corresponding project and actions (“anchoring herself in the goal”), the patient continues to develop the feeling of despair and seeks other crises that correspond to this feeling. In this way, she “anchors” herself in a feeling that she keeps “alive” by switching her attention to ever new issues and problems. We know that physiological processes also belong to a feeling and emotion, which exhaust themselves after 20–30 min and they flattens out. However, by paying attention to other issues associated with the same feeling, such as fear, the feeling can be kept active and effective for much longer. Anchoring in a feeling and emotion, rather than in a goal that enables a problem to be solved, suggests other actions, disrupting action and project organization. Long-term concerns are not translated into medium-term projects, which are then not materialized into optimal actions. Thus, neither needed actions to solve problems, nor actions to reduce intense feelings are undertaken (goals that represent a realistic goal order or hierarchy), but actions are initiated that disregard this hierarchy. This includes the goal of exiting life so that certain problems are solved, or in response to the perceived futility of life.

Finally, the course of action of the suicidal action also points to the problems of action organization. The patient decides to die, prepares the medication for overdose, and her acquaintance calls and visits her, causing her to abandon her plan. While it is highly commendable that in this brief encounter the patient moved from her momentary suicidal intent, it is still surprising how little such an important "life or death" decision was anchored in a goal system. The patient described her suicidal action as a knee-jerk reaction. However, this testifies less to a "short-circuited" reaction than to the inaccessibility to the patient of the whole action organization of suicidal processes. She was not aware of her suboptimal problem-solving habits, nor of her existential threatening feelings of "abandonment," which then suggested to her other than rationally considered goals. She acted as if these feelings of threat adequately represented her life situation.

► **Summary**

1. The problems of the order of action relate to the hierarchy of goals in long-term, medium-term and short-term goal-directed processes. In addition, they concern the confusion of the steering, control, monitoring and regulation processes, as well as a hierarchy in the action system.
2. As with every suicidal action, the concern "to live" also sinks in the hierarchy of importance of goals for this patient. The partnership must be right, the family must be kept together, the sons should be happy, and other goals are also considered more important. If these goals are not achieved, life becomes meaningless.
3. The patient learned from her father, who repeatedly threatened suicide, that life was only a means to an end and not a value in itself. Therefore, she also repeatedly considers suicide as a problem-solving option.
4. The problems in the hierarchy of goals are not anchored in an uninformed rationality, but in the threatening feelings which the patient associates with certain problems (I feel abandoned, I feel lonely) and which she then deepens in alcohol consumption. In this way, she can also suspend the usual order of short-term actions and generate destructive goals.

9.2.3 Suicidal Action: Consciously Prepared or Spontaneous?

With these considerations we are already dealing with the question of "top down" or "bottom up" steering of the action, or was the action consciously aimed at, or reactively carried out? Even if the patient was not surprised by her action and gave good reasons for suicide (does not make any sense, nobody needs me, etc.), she still stated that it was a short-circuit reaction. We elaborated above that she was rather unaware of the hierarchy of goals of her actions, because she acquired some prerequisites for suicide. She learned this alternative action from her father "on the model". In addition, she also learned to reinforce negative emotions by becoming aware of problems rather than addressing these problems individually with problem-solving intent. This approach by the patient is reflected in the framing

of her narrative about her suicidal crisis. The patient evokes her feelings of overwhelm, impending loneliness, etc. in the treatment of one problem and then pivots to another problem with which she again associates these feelings. When she finishes describing her main problems, she starts again from the first problem.

However, the patient's characterization of her suicidal action captures the fact that her value and goal system would not "provide" this solution, but that this alternative action (suicide) was adopted because of other mechanisms. Thus, this suicide action was performed as a goal-directed action. The switch from a life-affirming project to a suicide project occurred because of the association of certain feelings experienced as existentially threatening with the alternative action of "suicide," which the patient learned from her father. In a conversation with her acquaintance, the patient was able to postpone the suicide goal, if not give it up, at least for a week. The blunt razor blades with which she unsuccessfully attempted to slash her wrists moved her only to abandon the blunt razor blade and to intend to go to the bathroom for a new one, not to abandon the destructive goal of ending her life. Such a consideration, however, calls into question the short-circuit reaction thesis. We can assume that a short-circuit reaction allows for unconscious regulation, but not for an action-step alternative due to conscious control processes, such as "the razor blade is blunt because I am not achieving what I want with it. I'm going to get another one". The patient saw no way out in her life and then went to the bathroom to get a razor blade. She did not say that she saw no way out and then saw razor blades in the bathroom which made her think of suicide. The repetition of the suicide attempt after a week is evidence of a persistent goal, or connection, between the way the patient elicits her existentially threatening feelings of "abandonment," how she perpetuates the feeling with the actualization of other problems, and the alternative action of "suicide." This connection is also solidified by the serious suicide attempt already made years ago, a connection also confirmed by the research data.

▶ **Summary**

1. The patient gives good reasons for suicide, but describes the suicidal action itself as a knee-jerk reaction, i.e. something that was not planned in advance.
2. The change from a life-affirming project to a suicide project did not happen through planning ahead, but through certain feelings she experienced as existentially threatening, which she learned from her father were the reasons for suicide.
3. The repetition of the suicide attempt after one week is evidence of a persistent suicide goal.

9.2.4 Problems of the Action Monitoring Processes

Action monitoring in the form of pain, emotion, and awareness/attention is often shown to be problematic in suicide processes. This patient did not speak of any extraordinary changes in her perception of pain, as many other individuals do after a suicide attempt,

although she did not report pain that she was sure she felt during the cutting. The patient's emotional monitoring at the time of the suicide has been addressed above. The most important issue in this relationship seems to be the emotional memory of "abandonment". The patient herself mentions, "Since I've been in the world I've just always been abandoned by everyone". She also recognizes that this played a crucial role in the suicidal action "Yes. So it is always so about the theme of abandonment and being abandoned". The problem with action monitoring, in which this feeling plays a significant role, is that this memory of feeling replaces ongoing situation monitoring. This is a substantive problem because the person then acts on the basis of this false report and not on the basis of the situation mirroring. This does not affect the issue of objectivity, because every reflection is personal, i.e. subjective. However, a feeling that comes from an emotional memory has little relation to the actual situation and is misleading, especially in its intensity, which often reaches the level of an existential threat. A father threatening to kill his children and thus abandon them, which is existentially threatening to a child, may contribute to the child and adult later recalling this emotional memory when experiencing a situation of "abandonment." This patient experienced this situation several times and also repeatedly responded to this feeling by attempting suicide.

To what extent was cognitive monitoring by means of consciousness and attention also disturbed? The patient knew what she was doing. However, we mentioned above that she lacked insight into the goal contexts of her suicide. This is not a question of the unconscious, which is present in all action; in an optimal action only the deepest level of action organization, action regulation is unconscious. That is, the flow of movement in a habitualized action is mostly unconscious, like the movements in riding a bicycle. This level of action organization can also become conscious when, for example, we learn a new movement sequence, as in sports, dancing, or similar skills. On the other hand, we are not always aware of the sources of our comprehensive goals and values, because we acquired them in our socialization process. Between these comprehensive preferences and the regulation of action at the lowest level of action organization, we try to consciously order and relate our actions into long-, medium-, and short-term aspirations and actions. This seems to be problematic with the patient, as she revealed. She let us understand that she had no insight into the goal contexts of her suicidal action, and that the suicidal action therefore appeared to her as a short-circuit reaction.

► **Summary** The emotional memory of "abandonment" plays a crucial role in the suicide action. This emotional memory replaces the ongoing situation monitoring.

9.2.5 Problems of Action Energization

The patient describes her situation immediately before her suicide as "I saw no way out" rather than "I couldn't take it anymore," which would indicate a lack of energy. So there was a lack of a valid alternative and not lack of energy to tackle her problems. She

complains about the lack of energy only with regard to her work, which requires strength and energy from her, but not with regard to her life: "I was no longer able to do my job at that point. I am a masseuse. You need a lot of strength and energy to do that. But this I simply no longer had." Nevertheless, one must also accept certain problems of action-energizing in the suicide action. Most notably, the energy to reject an emerging alternative action – suicide – because of the fatal consequences, and to initiate problem-solving strategies in the form of relevant action. The effecting of a change of action and goal by her acquaintance in a relatively short conversation testifies to the low energy level at the moment of the suicide action, with which no own change of goal and action was possible any more.

▶ **Summary** The patient showed problems of action energization. She could not muster the energy to reject an emerging alternative action – suicide – because of the fatal consequences, and to initiate problem-solving strategies in the form of relevant actions.

9.2.6 Suicide and the Interactive and Joint Action

Can this patient's suicidal actions also be understood from her shared actions with others? The patient speaks of several relationships that she sees in connection with her suicide attempt. First of all, it is the relationship with her young boyfriend and partner, who leaves her after an 11-year relationship. Her goal was apparently to continue the relationship and discuss pending problems. Both were disappointed. The fact that the partner left the patient suddenly and without warning for another woman and refused to discuss the existing problems certainly played a role. In addition, he called the patient repeatedly over several months to complain how unhappy he was. Then, when the patient became hopeful that he might return, he categorically rejected this request. At the same time, the patient witnesses her nineteen-year-old son struggling with insecurity, career dissatisfaction, lack of independence, and dependence on his mother and wanting to move in with his girlfriend. The patient wants her son to live a content life, gradually building his independence and only shifting his center of life in consultation with his mother. She has not been able to achieve this either. From her younger son, the patient wishes that he would be at home more often and not constantly out with his friends. She felt abandoned by these close persons and complains that she sacrificed herself for them for a long time, but in the end nobody is there for her. She said she wanted to be able to lean on them once in a while. She elaborates with the psychiatrist that the theme of "abandonment and being abandoned" is very important in her life, and also played a crucial role in the suicide attempt.

While the encounters with others were often stressful, they were sometimes life-saving. The patient reports how, at the moment she was ready to suicide by medication overdose, she was called by an acquaintance who then also visited her at home and spent the evening with the patient. Also, during the second suicide attempt a week later, when she tried to slit

her wrists, her son and his girlfriend came home unannounced at midnight, saving her life. The patient also recounts other relationships and encounters that she associates with her suicide attempts. This was initially the relationship with her father, who often threatened suicide, which overwhelmed the children. When the patient fell in love at the age of 21, but was already in a longer relationship and her boyfriend threatened her if she left him, she overdosed on medication. We pointed out earlier that her father's handling of suicide also shaped the patient's handling of this issue. Thus, the alcoholism of her husband, with whom she spent 12 years, could also lead her to excessive drinking. Last but not least, it is also worth mentioning the patient's relationship with her psychotherapist, which she enjoys in her psychotherapy that has already lasted for some time. It is therefore obvious that the patient would have to work out an appreciative relationship to her life, see the meaning of her life in closeness attainable through her own doing, and finally also change the way she forms her relationships so that her goals and expectations become visible and realizable in the joint projects and processes.

▶ **Summary**

1. In connection with her suicide attempts, the patient tells of several important relationships and joint actions with other people.
2. She describes the broken relationship with her ex-boyfriend as crucial. She is very concerned about her son, who is struggling with a lot of insecurity, professional dissatisfaction, lack of independence and dependence on his mother and wants to move in with his girlfriend.
3. Other relationships and encounters proved to be life-saving. At the moment when the patient was ready to commit suicide by medication overdose, she was called by an acquaintance who then spent the evening with the patient. On the second suicide attempt a week later, her son came home unexpectedly with his girlfriend, thereby saving her life.
4. The patient also describes relationships and joint actions from her youth as important for understanding her suicide attempts. She felt overwhelmed by her relationship with her father, who often threatened suicide. When she fell in love with another man at the age of 21 and her then ex-boyfriend threatened her, she overdosed on medication.

9.2.7 The Woman's Conversation with A Psychiatrist

The young psychiatrist informs the patient that she only knows her name and that she would like the patient to tell her how her self-harming actions came about ("…if you could tell me how it could have come to this from your point of view"). At first, the patient says that it is not easy, but then she tells everything she associates with these actions fluently, in detail and with commitment.

In the **first joint action** the psychiatrist formulates the joint task, the patient accepts it and reports in detail about her experiences which led to the intention "to die". She tells about her two sons, about her partner who separated from her after 11 years together, how hard it was for her and how she was tormented by her boyfriend's behavior. After 882 words, the psychotherapist asks whether the patient is now talking about her son or her boyfriend. After another 845 words, the psychiatrist recapitulates that the patient spoke all this about her boyfriend on tape, which the patient confirms and moves on to the second joint action.

In the **2nd joint action** the patient describes her state of mind before the suicide action, how she had the feeling that "…one way or another nobody needed her anymore, that at my age life was just over. Then I felt like… I don't know. I just, like I said, didn't see the point behind it all anymore. I didn't know why I should go on."

Here the psychiatrist initiates the **3rd joint action** by asking how exactly this happened on this day. She specifically asks whether this was in the morning or in the evening when the patient spoke to her boyfriend on the tape, whether she expressed the wish to break off contact with her boyfriend for the first time on this day, whether all these details were really spoken on the tape, whether not knowing what she was doing with her boyfriend was the most difficult thing about the relationship crisis, and whether the patient really wanted to draw a line under this relationship. The psychiatrist confronted the patient with her impression that although the break-up could have been a relief, this was obviously not the case, and thus leads on to the fourth joint action.

In the **4th joint action,** the patient reports the critical evening, how she thought her boyfriend would never call again and started drinking alcohol. The psychiatrist elicits how much and what the patient drank. In the second part of this action, the patient reports how much she was also burdened at that moment by thoughts of her son's problems.

In the **5th joint action,** the psychiatrist picks up on the feeling that the patient described as "feeling left alone and abandoned," which led the patient to state that "(s)ince I'm in the world I'm just always abandoned by everyone." The patient wanted to take an overdose of pills, but was called by an acquaintance who sensed the patient was not well, visited her, and stayed with her all evening. The patient tried again after a week. She cut her wrist with razor blades until she was surprised by her son and his girlfriend. She then described their conversations and how she was cared for by the young people.

The psychiatrist opens the **6th joint action** by asking how the patient subsequently came to the clinic. The patient reported about her psychotherapy, which she already started before the suicide action and mentions her inhibitions to seek professional help in moments of crisis.

In the **7th joint action,** the women discuss the key issues of the suicide crisis, that the patient really wanted to die and that there is still pain in her wrist today. The patient recapitulates the decisive moments of the suicidal action.

The **8th joint action** develops around answering the question about the patient's suicidal thoughts in the past year and also overall in the patient's life, where the psychotherapist formulates the patient's most important issue as "abandonment and being abandoned".

In the **9th joint action,** which the psychotherapist introduces with a question about the patient's childhood, she reported about her father's suicide threats and how she still has problems now when she wants to better separate herself from the family of origin.

The two women devote the **10th joint action to** the patient's present condition. She talks about her son and also in detail about other experiences with her boyfriend, who keeps contacting her, even if only through her acquaintances and friends. The young doctor then talks about the patient's cooperation with her psychotherapist.

In the **11th joint action,** the conclusion of the conversation is initiated and executed.

▶ **Summary**

1. The conversation between the two women takes place in a trusting atmosphere in which the patient dares to talk in great detail about her suicidal actions and her state of mind.
2. In the 1st joint action they establish the joint task and the patient tells about her experiences that led to the intention "to die", about her two sons, and her partner who left her. In the 2nd joint action she describes her state of mind before the suicidal action, how she felt that at her age life was over. Thus, in the 3rd joint action, the psychiatrist asks what exactly happened on that critical day. In the 4th joint action, the patient tells how she felt that day and therefore drank alcohol. Then in the 5th joint action she describes how she felt left alone and abandoned since she was in the world – how she would always be abandoned by everyone. The patient wanted to take an overdose of pills, but was stopped from doing so by an acquaintance. Then a week later she wanted to die by slitting her wrists, and was surprised by her son and his girlfriend. In the 6th joint action, she talks about her inhibitions about seeking help from others when she has problems. In the 7th joint action, the women discuss the key issues of the suicide crisis, and the patient recapitulates the crucial moments of her suicidal action.
3. In the 8th joint action they discuss the suicidal thoughts in the patient's life and the psychotherapist formulates the patient's most important problem, "abandonment and being abandoned". In the 9th joint action, the patient talks about her childhood and describes her father's suicide threats.
4. In the 10th joint action, the patient's current condition comes up. She talks about her son and other experiences with her boyfriend.

9.2.8 Self-Confrontation Interview

The interviewer first asks the patient how she felt when she saw herself on the video ("How did you feel when you saw the first sequence on video?"). The woman is initially undecided, saying it felt strange to hear herself speak and see herself on the screen. She describes it as alienating, but not unpleasant.

The interviewer then asks the woman, as well as he did the other participants in the study, what it was like for her when she told it, what she felt at the moment of telling it, and how she felt while telling it. In the **1st section,** the patient reports that she experienced strong emotions while telling ("It takes me away when I tell it"), that she was in pain while telling ("It still hurts me"), and that she also cannot understand it cognitively, i.e., mentally ("It is still incomprehensible to me. It is incomprehensible to me that one can act in this way"). In the self-confrontation, the woman tells about all the monitoring systems as they were claimed during the narrative interview. What is incomprehensible to her is that her boyfriend left her without talking to her about it. She subsequently describes how he kept rejecting her attempts to talk to him about their relationship. We learn more details about her boyfriend and their life together in the self-confrontation. She is ten years older, and he was 23 when their relationship began. She tells of how she would often pick him up by car after midnight after work in the city, and while there she met his work colleague, with whom he later began a brief relationship. For this he left the patient after 11 years of living together. She briefly mentions her job, which she does not really want to continue doing, as she is currently too weak for it. Asked how it was for her to talk about her suicide attempt, the patient characterizes herself as an open-minded person, very strong-willed and goal-oriented ("When I have a goal in mind, I want to achieve it. I am not a person who starts something and then gives it up halfway. I just make sure that I reach the goals I set for myself."). However, the woman also tells us that this single-mindedness was often expected of her from the outside and pushed at her, and that she is currently no longer able to do it ("But I have now simply reached a point where I no longer have the strength for it. I don't know… It's always been demanded of me throughout my life that I do it this way, that I can pull everything off this way. My parents, my kids, my ex-husband, and him now too… – They're all convinced that I'm just going to drag it on now, that I'm going to keep doing everything on my own. He (ex-boyfriend) says that this is not a problem for me at all. After all, I have always achieved everything in my life. So I will continue to achieve it. But no one has noticed that I also need someone to lean on, to do something for me for once too. I need someone to look to me once in a while too. I just can't always.". She, in her mid-forties, perceives this as an existential life crisis: "Now I'm at a point where I can't go on. I just don't see a way out anymore. This is also due to my age. Life is already over for me now". The patient reports further that she once went to the doctor, was prescribed antidepressants, which she did not tolerate, vomited and stayed at home for a week.

2nd section: In this section, the interviewer completely forgot his task of asking about the thoughts, feelings, and sensations during the section shown at the time of the interview. Instead, he asked about the patient's thoughts in her argument with her boyfriend. She reports how she tried to make it clear to her boyfriend that she did not want to be in a relationship after he left, nor did she want to talk to him. She wants a new beginning, she says. The interviewer then inquires about her son and the patient elaborates on her concerns and her experiences with her son. She also lets us in on her torn relationship with her son. On the one hand, she wishes the 19-year-old young man great independence. On the other

hand, when he announces that he wants to move out of the apartment they share, she issues the threat that he will then no longer be allowed to show his face at home.

The self-confrontation interview is terminated because the patient had to attend another appointment.

Summary

1. In the two sections of the self-confrontation interview, the patient offers much additional information in her detailed narrative.
2. She states that she experiences strong feelings when narrating, that she is in pain and that she cannot mentally comprehend what she has done and thus narrates in self-confrontation about all monitoring systems.
3. We learn more details about her boyfriend and their relationship in the self-confrontation.
4. The research assistant does not inquire about the thoughts, feelings, and sensations during the section shown at the time of the narrative interview, but inquires about the patient's thoughts during the confrontation with her boyfriend.

Case 8

10

10.1 Suicide Story: René – I Am Not Needed in This World Anymore

Annette Reissfelder

His friend Peter had said that no man could understand what women wanted, and that was a fact. René had always believed that *he* knew very well what women wanted. You had to be able to offer a good woman a good life – a nice home, financial security, holidays, and a harmonious family.

He had a good wife. He had already achieved a lot in life. He enjoyed the respect of both colleagues and employees, and his boss trusted him. He valued professionalism, and was dedicated, but always maintained his professional distance. Especially with co-workers, this was crucial. Some found him too precise and thorough, he knew. But success proved him right. His restaurant received top ratings, there were never any quality or hygiene issues, and the customers were satisfied. That was his job, after all, and he devoted all of his energy to it. It had always been that way, even in previous positions. By now he could have chosen where he wanted to work; there was certainly no shortage of offers. The next step would be to manage a larger restaurant, perhaps in a different location, where the family would also be comfortable.

His wife didn't need to work, that was important to him. Rita was a sensible woman and kept the money together. She got by on her housekeeping money, and was usually even able to contribute to their holiday fund. She ran the household just the way he liked it. A well-coordinated team, as he always said.

Rita and he had known each other for seven years, for five of which they had been married. They had only really gotten to know each other just before they got married when they had started thinking about having a child. That had been important to him. Then, soon

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after the wedding, Rita had become pregnant. He still loved her after all these years like he used to. And now he had lost her. Could things ever go back to the way they were now that she had cheated on him?

He liked things to go as planned. Routines and procedures calmed him down. This gave him the feeling that he has everything under control. He had already learned as a child how important control and discipline were. Other boys had much bigger issues with their diabetes. They couldn't cope with the calibrations, and then they were miserable. He, on the other hand, always knew exactly what he could still afford to eat. His routines worked.

Lately, there had been lots of things that he had not been able to be put into routines. That's why he'd had to work more and more. He had aways worked a lot, and didn't know any other way. For a good restaurant manager, there was always something to do. Rita couldn't understand that. But then, her parents never had a position of responsibility. Her mother was a kindergarten teacher, her father a counter clerk. Of course they could always be home at the same time. But he had to take care of everything that no one else saw or could decide – and there were always unforeseen problems, sometimes so many that he couldn't even get to his own tasks during working hours. Above all, the employees and temps were a lot of work; they got sick, had to go to the doctor, pick up their child, or accompany their mother somewhere with no advance notice. They made mistakes, which someone then had to fix, not infrequently himself. They wanted advances, unpaid leave, or changed shifts, sometimes even without consulting him – they were cats to be herded. And the guests weren't always easy, either. Recently, a guest had fainted, and sometimes they had to check the register several times a day because a guest claimed he didn't get his change out properly. In the end, he had to make sure that everything ran smoothly, that everything was in the right place, and that the customers were served perfectly. He had no one in his team who could be relied on 100%. His wife couldn't understand that, she only saw the result. And then she thought that he earned too little for all the time he spent working.

Sometimes she seemed to think he worked so much to be away from home. Yet he worked so much to give her and the boy a good life! They had everything they could wish for – and how could he have earned enough for that as a low-ranking employee? Nothing comes from nothing, as he always said, what was there not to understand about that? Her parents had both worked for years after Rita had entered secondary school, and yet they lived in a small rented flat. Her parents had rarely been abroad either. They, on the other hand, had already been to Lake Garda and Paris, and were now planning two weeks by the Mediterranean. This was possible thanks to the bonus he would be paid in July – which was why it had been so important, especially in the last few months, that everything went as smoothly as possible.

He had so hoped they could make a new beginning. It could have been so nice – especially now that the holiday was coming up! He had decided not to make a special repayment this year, but to invest everything in a nice holiday. He'd chosen a hotel by the seaside, had even splashed out on a balcony with sea view. He had imagined how nice it would be to have a glass of wine with his beloved Rita in the evening, and so maybe

rekindle the flame, erotically as well. Rita hadn't wanted him for a long time, she was either tired or rejected his advances directly. For a year, he hadn't even tried. And then he had come up with this vacation. Rita had been happy, but not quite in the way he'd hoped. But still – they would spend time together, completely without work, and they would become closer again.

That's why it was such a blow when he noticed her infidelity. But not only had he sensed it immediately that night, he'd said it to her face and hadn't let it go – not until she'd admitted it. A slip, a one-time thing. With a man she was sexually attracted to. And with whom she then did all the things she didn't like to do with him. It was just too humiliating. Why did this have to happen to him of all people!

He hadn't felt this hopeless since he learned as a boy at 15 or 16 that he couldn't even become an air traffic controller, let alone an airline pilot, because of his diabetes. A world had collapsed for him then. All his youth he had been interested only in aircraft, and owned every kit, and knew every type of plane and helicopter. All his spare time had been spent at the airfield. He could have been an aircraft mechanic, but that would have reminded him all day that he wasn't allowed to fly. Besides, the smell of machine oil made him uncomfortable.

He had overdosed on insulin back then in a moment of weakness, but had caught himself right away and eaten a lot of sugar to keep from sliding into hypoglycemia. No one had noticed anything. He'd stopped obsessing about planes from one day to the next. That had been about ten years ago now. In all that time he had never had such thoughts again.

What he had learned today would have been a serious slight to any man. But there had been no alternative – he'd had to know what she had done. The uncertainty of the last week had almost consumed him. His thoughts had kept circling around his wife and this man; he just hadn't been able to get it out of his system. He had been correspondingly absent-minded and unfocused at work. He couldn't go on like this.

He did not succeed in calming himself down. He just lay in bed and cried. No matter what he had done for her in the last week, since he had confronted her, she hadn't responded. He had tried to show her he was there, had walked up to her and she had frozen. He couldn't reach her anymore. If that was the case, he had lost the most important thing in life, his fine and sensitive wife whom he loved above all else. He knew what to do now.

10.2 Suicide Analysis: It Does Not Need Me in This World Anymore

Ladislav Valach

Asked by the psychiatrist about the "…when it was and how it came to this…" of the suicide attempt, the young man describes the week at the end of which he (suffering from diabetes) pumped himself a fatal overdose of insulin. He sees this action not only as a response to his wife's infidelity at the beginning of that week, but he embeds it in their

relationship, which he describes from his wife's point of view "She just told me that she couldn't develop any feelings towards me (for a year). She told me that I had never been home since then. She just lacks feelings towards me – sexual feelings towards me. It's not that she doesn't love me anymore, but she just lacks the sexual feelings toward me." The marital relationship is not the only mid-term and long-term concern that the patient talks about in relation to his suicide attempt.

10.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

10.2.1.1 Medium-Term ("Projects") and Long-Term Concerns

Already in this "marital relationship" there were several long-term processes that separated the patient, as well as his wife. There was the "mutual love", "the sexual feelings and the sexual relationship", as well as "the parental care and love" for their young son. For the patient, other concerns also showed up as important, such as "career", "work ethic", "relationship with brother", "relationship with parents" and especially "coping with diabetes", "life", "being in control", "reciprocity expectations", "marital fidelity" and many more.

10.2.1.2 Long-Term Concerns

The young man's long-term concerns include his "relationship with his wife," which spans several years, as well as his coming to terms with his "diabetes" and its consequences. He relates that when he was about 15, unable to take up the apprenticeship for his favorite profession because of the condition, he pumped himself with an insulin overdose. At that time, however, he was able to change his intention while still attempting suicide and saved himself by eating lots of sugar. This also addresses a concern that he was able to retrieve: the "suicide career". Another concern relates to his "work commitment" and "work ethic" that he learned about in his parents' home. His parents were self-employed and "…I had to consider myself lucky if I saw my father briefly on weekends."

For about a year, when he started a new job, he did the same: "I worked 7 days a week, 12–15 h a day. I always said that the further you climb the career ladder, the more responsibility you have, the more you have to perform and work." The patient sees this commitment in the new job as closely related to the marital relationship and his suicide attempt. "And it's also that she has had absolutely no sexual feelings towards me for a good year. That's because I'm just never home." The patient describes his concern of "reciprocal expectation," which he used primarily during the marital crisis and which proved ineffective because he was unable to communicate his desires. The "relationship with his brother" also comes into play especially in his life crisis when his wife asked his brother for help and he came immediately after, vigorously roused the patient and took him to the hospital. This expectation of reciprocity and "not communicating his own wishes" is also evident in his suicide justification ("being needed") when he says, "I was just so down, so broken, that I said I am not needed in this world anymore." He also uses this to justify his disposal of his own life. He does not portray his subordination of his own life to other concerns as

not being able to live without the woman he loves, but "… nothing came back from my wife… that destroyed me… that's what finally made me commit this action", "I've achieved everything so that I can now leave…", "… I was not concerned with the problem that she had cheated… I was simply concerned with what she could feel with this man and not with me…", "… I always had the question what she had had with the other man. That was simply the point which broke me, which had driven me to all this", "… I studied and cried like a castle dog…", "… I have nothing more to do in this world…", "… all this has no meaning anymore…", "I have a child whom I love more than anything in the world. I have an excellent job. I am also in high demand at my job. At this moment, I just had to say that I have achieved everything, that I can now leave." When his brother suggested to him "…there was no woman in the world worth giving up your life for" the patient nevertheless contradicted him, "That's when I told him that wasn't true." Another, though not very explicit, concern of the patient was "to please the boss". With a working day of 12–15 h last year, the patient was aware that he was neglecting his wife. Nevertheless, "I would already be willing to work less. But how does my boss see it? It's just two pairs of pants… That's the way it is in this day and age. You can't just tell the boss that you're going home now." A very important concern of the patient is his love for his son, which he tragically does not see in the duly long-term time horizon. He did say, "I love my son more than anything," but thinks that he can leave a good memory after an evening of playing with his son, so he could commit suicide: "My son would still have fond memories of me. After all, I had played with him that night."

► **Summary**

1. The patient tells of his present and past suicidal actions, which would not be conceivable in this way without his "diabetes and his concern to control this disease". In the first suicidal action, the disease played a decisive role because it prevented him from taking up his favorite profession. This concern is thus closely linked to his other lifelong concern "to live".
2. His other long-term concerns include his "relationship with his wife," "professional career," his "work ethic," his "relationship with his brother," and his "relationship with his parents."

10.2.1.3 Medium-Term Concerns – "Projects"

Within these longer-term concerns, the young man achieved some of his medium-term intentions. However, he was unable to address the obvious conflict between his concerns of "commitment to his new job" and "maintaining his relationship with his wife", resulting in a marital crisis which he tried to end with his suicide. He still reported a "relationship with a friend" who offered him a "new job" in another city, but whose proposal was too noncommittal for the patient in marital crisis to perceive this as an offered hand, so it did not deter him from his suicide attempt. Another concern that is only now beginning to emerge is the "marriage counseling or therapy" that the couple would like to seek. However, the patient expects that it will become clear in the first session whether his

acceptance of the new job in another city will be beneficial for the marriage and the patient and therefore he can make the decision, since he would have to hand in his resignation from the current job soon. His mid-term concerns and projects include his "suicide attempt" and, most importantly, the "marital crisis." Although he describes both concerns as sudden in onset, both processes were predictable in their culmination. The young man had already chosen the method of massive hypoglycemia by taking insulin when it was not possible for him to choose his favorite profession because of his diabetes. He also resorted to the same means in his marital crisis. However, it is not the means of the suicide attempt that is decisive, but the way he understood the projects whose difficulties he had to solve. He could not break away from this understanding, so that he proceeded in the same way when the marital crisis loomed. In this concern, too, he allowed a long time to pass without addressing the neglected sexuality in the marriage. He speaks of one to three years when they did not maintain their sexual relationship so that his wife began to doubt her own ability to love.

▶ **Summary**

1. Directly relevant to suicide is the patient's marital crisis. This includes his conflict between "commitment at the new workplace" and "maintaining the relationship with his wife".
2. A role is also played by his "relationship with a friend" with whom he also talked about the possibility of a "new job", from which he also expected a solution to the marriage problem.

10.2.2 Short-Term Actions

Marital Crisis; Patient (P), Wife (E), in-Laws (Sch), Colleague (K):

Cognition P: It (suicidal action) happened in the evening.
Action E: It came to this because a week ago my wife cheated.
Action P, E: I was able to tell her that same night.
Cognition P: And that's when my problems started… – Why? Why my wife? What did I do wrong?
Cognition P: I just felt that. On Sunday morning, when she was getting dressed….
Actions P, E, Sch: Throughout the day, the in-laws were visiting us.
Action E: Then in the evening she insisted on going to visit a friend. She said that the friend was so alone that her boyfriend had abandoned her.
Action P: I then told her that she would now just leave me and the little one alone.
Action E: She then told me that yes, she would see us again and again.
Cognition P: At that moment I just felt that something could not be right.
Actions P: So then I went after her in the car.

Cognition P: And when she got off the highway in A. instead of going to B., I just had to say that something must really not be going well.
Action P: I then wrote it down on a piece of paper for her that night.
Action P-: I then couldn't sleep through the night.
Action P: But I just pretended to be asleep when she got home.
Cognition P: I just tried to process all this for myself first.
Action P: I just wrote it down on a piece of paper. I wrote her that I have the feeling that she has now just cheated on me and that she should now think about it once.
Joint Action P, E: I then called her in the morning. But there she still told me that she had only been with the girlfriend. But I just told her that when I would come home in the evening, she should tell me.
Action P: When I arrived home I took her bag, which she had with her that night, upstairs.
Action E: That's when she admitted it.
Cognition P: Then at that moment all my thoughts came – Why my wife? What did I do wrong? I then tried to figure out the problems.
Action E: She simply told me that she couldn't develop any feelings towards me since I started working at M's place.
Action E: She told me that I had never been home since. She just lacks the feelings towards me – the sexual feelings towards me.
Action E: It's not that she doesn't love me anymore, but she just lacks sexual feelings towards me.
Cognition P: That just made me wonder why we never did it.
Actions P: I then tried to give her that love for the duration of a week.
Actions P: When I told her I'd be home at 4:00, that's when I was home at 4:00. Maybe once it became 4.05 p.m. But it was not like before, when I came home only at 8.00 p.m. each time and also took the work home with me.
Joint Action P, E-: I never got anything back that whole week. I put all my energy into our relationship.
Cognition P: I always had the feeling that something should come back after all.
Action P: On Monday night it was so that I massaged her feet and legs because she was in pain.
Action E-: Nothing came back at this moment either.
Joint Action P, K: In the evening a colleague called me to ask me whether I wanted to work for him or not. He wanted to have me very much in the company.
Cognition P: That's when I got to the point where I had to say… There was just nothing coming back from that woman. I do have a family, too. I have a child who I love more than anything in the world. I have a great job. I am also in high demand at my job. At that moment I just had to say that I have achieved everything, that I can now leave.

Suicide Action P:
Emotion P: I was just so down, so broken, that I said I didn't need to be in this world anymore.

Action P: That's when I injected myself with insulin.
Cognition P: Yes. If they hadn't found me, that dose would have been fatal.

The Marital Problems/Crisis; Patient (P), Wife (E):
Cognition P: We felt like we were talking about it together.
Cognition P: I was also not concerned with the problem that she had cheated.
Action P: I just said she couldn't tell me any other way.
Actions P-: I was just never at home, just always on the road.
Action E, P: She just tried to tell me in a different way. This action simply represented a slip, which can happen to anyone.
Cognition P: We felt like we had talked about it together.
Joint Action P, E-: But we never talked about the point that really bothered me.
Cognition P: I was simply concerned with what she could feel with this man and not with me.
Action E-: She didn't tell me that until yesterday.

Common Actions; P, E: Argument:
Joint Action P, E: Yesterday we were driving home on the highway. We were at my parents' house.
Action P: I left the motorway in A. and told my wife to tell me now where to go through.
Action P: I simply told her that I wanted to know everything now.
Action E-: She didn't want to tell me anything at that moment either, at first.
Emotion P: I then freaked out quite a bit.
Action P: Therefore, I drove home in a rage.
Action P: I then got off at home and simply said that I no longer wanted to and could no longer.
Action P: I told her I didn't want to see her now.
Joint Action P, E: We then still had a conversation together.
Action P: I simply told her to tell me what had happened. That way I wouldn't have to just imagine anything, but would know the truth.
Action P: I simply told her that I wanted to know the truth, that I didn't want to just make up fantasy versions that would end up eating me up.
Action E: She then told me the truth.
Emotion P: In the beginning, this hurt a lot. That is also logical.
Emotion P: But at this point, I have to say I'm glad she told me.

The Days Following the Argument; Patient (P), Wife (E), Friend (F):
Action P: I was able to sleep at night for the first time in a week and a half. I couldn't sleep all the way through the night. But I could still say in the morning that I could now sleep for two to three hours without having to toss and turn in bed all the time, drenched in sweat.

Joint Action P, E: But spoken together as we probably should have done a year ago, we only did yesterday.
Cognition P: That is correct (it was then also the uncertainty which led to this action).
Joint Action E, P: It was finally that I was not allowed to touch my wife.
Action E: She always said right off the bat that I just could never let it go.
Cognition P: The question always came to me then, what she had had with the other man. That was simply the point that broke me, that drove me to all this.
Cognition P: This question led me to the point where I had to say on Monday night that I had now achieved everything and that I could now leave.
Actions P: I worked 100%. But you can say that I was just present and nothing more. It took me 15 minutes to do a job for which I normally needed 5 minutes.
Cognition P: I just thought about the past all the time.
Joint Action P, F: The next day I went away for two days on business with a good friend.
Joint Action F, P: This one spoke to me during this time. But he could not solve the problem for me. He also did not know what had happened.
Cognition P: In the end I simply had to say that it couldn't go on like this.
Actions P: I worked all day Saturday.
Joint Actions P, E, in-laws (Sch): On Sunday we had, … the in-laws over. I had… off on Sunday.
Actions P: On Monday, I went back to work. At 4.00 p.m. I came home.
Actions P, Child (K): I spent the rest of the afternoon with my child.
Cognition P: I always felt at that time that something must and will come now. But nothing ever came. That destroyed me. That's what finally led me to commit this action.

Suicidal Intention; Patient (P):
Cognition P: Yes. There should have just been something coming from my wife's side – an accommodation of some kind. I was just waiting for something. I was already up to my head in water. All she had to do was give me her hand. But no hand was extended to me. I also had the feeling that we had discussed everything together. In my eyes, it was impossible to talk about it anymore. At that moment I simply had to say that I would now leave this world….
Action P: I then went into the kitchen and cooked something delicious for dinner.
Joint Action P, E, child (K): We then ate all three together.
Cognition P: I just wanted to show her again that I was there for her.
Joint Actions P, E, child (K): After that we put the little one to bed – the normal ritual: putting on pajamas, straightening the "potty"….
Joint Actions P, E: After that we took a shower and then sat in front of the TV. There I massaged her feet and legs. At the same time we watched a film.
Joint Actions P, E: That evening, actually, everything happened that had happened every evening all week long. We showered, played cards together, or had a glass of wine together. We just did anything together.
Joint Action P, E-: But in all that time, there just never came a hand for me to hold.

Actions P: I then went to the bathroom and brushed my teeth. After that I went to bed.
Cognition P: I hadn't planned anything.
Emotion P: After the phone, I was already disappointed.
Action E-: Even after the leg and foot massage just nothing came back.
Cognition P: At that moment I felt it was good that the phone call came. I thought that it could distract me a little from all this.
Action P: But after the conversation, I just went to the bathroom and got ready for bed.
Action P: I told her that I just couldn't now, that I was going to sleep.

Project: New Job; Patient (P), Wife (E), Colleague (K):
Action P, K: Then I was called by my colleague.
Cognition P: The colleague who wants to hire me at his restaurant. But up until that point, there was just never anything that I could have held on to. Even the job offer couldn't hold me. I already have this position. I am in demand at my job – and still in other businesses. I just didn't get a hand that I could have pulled myself up on.
Joint Action P, E: She asked me who it had been. I said that it was the P. and told her that I had the opportunity to go to work on D.
Joint Action P, E: I then asked her if she would like and agree to come with me. Then she told me that we already had problems together. How should it look then after a move to D.
Cognition P: She was rather negative about it at first.
Action P: But I said at that moment that now I also have to think about myself for once. I can't just think about her all the time. I must also see that I can get strength somewhere. Therefore, I said that I will go to D.
Cognition P: The final decision will be made tomorrow. That's because we're still in marriage counseling tomorrow. We have the feeling that if she will tell us tomorrow that if we will do this and this and this, that then everything will be straightened out, that then the decision will be clear. If she is going to say that it is not very smart to go to D. now at this moment, then of course I will stay home. But if she will tell me that perhaps it would not be the stupidest thing at all if there were some distance between us, then I will certainly go to D.
Cognition P: It wasn't the first time I had talked to him about it.
Actions P, K: I was already in a course with him in November a year ago.
Actions P, K: Last March I visited him at his headquarters in Z.
Joint Actions P, K: That's when we discussed that I should have taken over a new restaurant in Z.
Cognition P: About that, my wife was positive.
Action E: She told me that she would come to Z. with me.
Cognition P: For me, it was more about starting over.
Action P, E: But when I told her that it was now D. and not Z… She had already lived in D. for four years. It would be nothing new for her.
Cognition P: But I think that distance might not even be the dumbest thing for our situation. It would at least allow me to switch off for a bit, forget what happened, and build something new. I could develop a new attitude towards our relationship. I think that if I

lived further away, the chance that I would do something like I did on Monday again would be smaller. The problem that will always be there, though, is the uncertainty. What does she do? What happens? That's certainly a problem. But the other way around, I also have problems….

Suicidal Action; Patient (P), Wife (E):

Action P: I was lying in bed,
Cognition P: studied
Emotion P: and cried like a castle dog.
Cognition P: I cried for the first time during all this time.
Cognition P: Then when I was crying like that I just had to tell myself that the smart thing for me to do was to leave now. My son still had nice memories of me. I had played with him that evening. And everything else is anyway….

Suicidal Action; Patient (P), Wife (E), Brother (B), Doctors (Ä):

Actions P: I then started pumping with the insulin pump.
Cognition P: Yes. It has a depot of insulin. I just have to refill this whenever it is empty. I just had the depot refilled the night before. Therefore, it was still almost full. At that moment I simply said to myself that I now pump into myself everything that is still there.
Emotion P: I just cried the whole time.
Action E: She then came into the room and tried to comfort me.
Action P: But I told her that I just wanted to be alone, and that I was going to sleep for a long time.
Cognition P: I think that in the back of my mind I still wanted her to notice what I was up to.
Action E: She then asked what that meant I was going to sleep for a very long time.
Action P. I just told her to let me sleep now and not to wake me up again.
Cognition E: And that's when she realized.
Action E: She tried to reach my parents. But my mother was not at home and my father was in the garden and did not hear the phone.
Action P: During this time, I was able to keep pumping and pumping.
Action E: She then called my brother.
Action B: This one then drove straight from home to us.
Action P: I was able to continue pumping insulin into myself for ¾ hour.
Cognition E: My wife finally didn't know what to do with me anymore.
Emotion E: She was very afraid for me.
Action E: She kept calling my brother on his mobile phone asking when he would finally arrive.
Action E: She also tried to reach my parents and my sister during the whole time. But she only reached the brother.
Cognition E: She just didn't know what to do at that moment.
Emotion E: She literally panicked.

Cognition P: I thought that was a good thing too – if she's panicking, then she can't come get me either. So I thought that I could really go to sleep now and I would be gone. That way I wouldn't have to tell anyone how much I had pumped into me.
Cognition P-: In between, I passed out – I went into hypoglycemia.
Action B: Then once my brother came. He gave me a slap in the face first of all.
Action B: Then he said we can talk together now.
Action B: Then he talked to me for about half an hour.
Cognition P-: I kept slipping away.
Action B: Then my brother told me to get up now and drink sugar water.
Action P: So I took 20 cubes of sugar already at home.
Action B: He then said that we were now going to my parents' house.
Action P: But I told him that there was not enough time. He should drive me to the hospital.
Cognition P-: Then I was gone. In between I came back and slipped away again – always back and forth.
Action Ä, P: In the hospital I got directly a 20% – glucose infusion.
Cognition P: I then lay with a low blood sugar level until 04.00 in the morning.
Cognition P: Important – I just have to say… He already asks me if I feel that something like this could happen again. Today I just have to say that in this situation, as it prevails at the moment, I wouldn't do it again – definitely not. But I also have to say that I don't know how I would react if my wife and I were no longer together. I just don't know what the situation would be then. I don't know how far down I would fall then. I would either say that this is the way it is and life must go on. Or the world would come crashing down on me. I just have to say here at this point that I don't know how I would react.

First Suicidal Action; Patient (P):
Cognition P: I have to put it this way… When I was 17 years old – or was I only 15 years old… It doesn't really matter.
Action P: I did the same thing then that I have done now. At that time, however, I saved myself of my own accord.
Cognition P: I just had to say at that time that life is too beautiful to just throw it away like that.
Cognition P: Since then, I had actually never given it a second thought.
Cognition P: But last Monday, I was just so low again… But in the span of time between Sunday a week ago and Monday, I had that thought for the first time on Monday.
Cognition P: The bad part is just getting here. I always thought that you could handle it yourself. But this is a problem that you can't manage yourself.
Cognition P: I just flew to the bottom – I dropped. I even dug the hole a little deeper so that I could fall even lower.
Cognition P: I'm just really down now. I now have to see that I can get back up. I try to be able to build everything up again.

Joint Actions Yesterday; Patient (P), Wife (E):

Action P, E: Yesterday she reacted because I had told her quite clearly that I now wanted to know what she had done with whom and how.
Action P: I said that I just had a right to know. It would be easier for me then and it would be easier for her because I wouldn't always be asking. That way I would know then. Then this would be closed for me.
Action E-: But she wouldn't tell me at first. From that point of view, she reacted negatively at first.
Action E: She told me I was crazy to do such a thing. I have a child and I still have her. I could always talk to her.
Joint Action P: But then I had to tell her that I had already lost my wife. Her reaction is still the same at the moment.
Joint Action P, E: Although she came here with me today and will also come to marriage counseling with me tomorrow.

Final Patient Assessment (P):
Cognition P: I see a ray of hope there already. We will now simply see whether we will come together again or not.
Action E: But that's the only thing she's doing right now.
Cognition P: But on the other hand, I also have to say that she's probably suffering as much as I am for all the garbage she's done.
Cognition P: But I don't think she's as strong as I am. She can't just say now this has happened and now you just have to move on. Time will just tell what the future will bring. ◄

► **Summary**

1. The patient describes a number of actions from his most important projects. They concern the marital crisis, his suicide action, the argument with the wife, the actions a few days after the argument, his suicide intention, the actions in the project of the new job, adds further actions in the suicide situation, talks about the help he received from his brother and the doctors, and tells about his first suicide action ten years ago.
2. The patient then describes common actions with his wife after his suicide attempt and then summarizes the present situation in thoughts and actions.

10.2.3 Problems of Action Organization

Action organization concerns the ordering of actions, projects, and long-term concerns. We showed in scientific publications that the organization of action is disturbed and defective in suicidal processes. In this patient, too, it is striking that he gave up the highest concerns, such as "preservation of life" and "caring for one's own child" for other, mostly short-term and by no means existentially significant concerns. Moreover, his reflections in this crisis show how he misjudges short-term concerns and actions in terms of their role in

long-term projects and careers when he thinks that his son, who is about three years old, will have fond memories of him, the father, after his suicide, after spending an afternoon playing together. In a similar vein, the young man expects that after only one session the marriage counselor might relieve him of his responsibility for deciding to accept or reject the new job away from home. In a similar context, we might also see his complete disconnect between the day-to-day maintenance or neglect of the marriage relationship and his expectation of the marriage working. His young wife, after years of sexual abstinence, began to doubt her ability to love and sought confirmation in this regard in an extramarital relationship. Moreover, for the past year he had been putting his professional concerns, his relationship with his boss, his professional career far above his family life, working 12–15 hrs a day and often leaving his young wife alone. His statement during the suicide crisis also testifies to a further shift in his goals and concerns: "on Monday evening I had to say that I had now achieved everything and that I could now leave. I have a child whom I love more than anything in the world. I have an excellent job. I am also in high demand at my job. At that moment, I just had to say that I have achieved everything, that I can now leave." One might imagine that this young man did not seek to achieve his successes for his life, to enjoy them, to make his life pleasant and happy, but assumed that his life was there for the achievement of those successes and that after that it had no meaning. He also had this thought immediately before the suicidal action "…there is no need for me in this world anymore…" The young man sees his concern "to live" as subordinate to the concern "to be needed". We can also locate the problems in the young man's organization of action, as well as the couple's, in how and whether they communicate their desires. We know that communication in joint action corresponds to thinking, to cognitive processes, in individual action. In the critical situation of the suicidal action, the patient wants to experience the affection of his wife, but he cannot communicate his wishes in any other way than to show her that he is ready to die. When she makes him understand that she sees his intention to commit suicide, the patient brings himself all the more eagerly into a state of helplessness. As if he wants to punish her with his death "for all the rubbish she has done…". The concern to "punish her" is more important to him than the concern to "live." When the patient follows his wife in the car because he is suspicious, he shows that his concern "to control the wife" and "to show up the wife in her bad deeds" is more important to him than "to communicate with the wife", "to get to know the wife's needs and wishes".

These and other problems of the order of action, but above all the appreciation of the most important concern "to live" would have to be addressed in order to build with it a life-oriented attitude.

▶ **Summary**

1. When "preservation of life" and "caring for one's own child" are abandoned for other, mostly short-term and by no means existentially significant concerns, then this testifies to problems of the order of action in the hierarchy of medium- and long-term goals.

2. The concern "the wife must not commit adultery" is higher than the concern "to live", "to be a good father to the child" etc. lacks any rational basis and is therefore to be seen as a problem of the patient in his order of the hierarchy of goals, the order of actions.
3. The complete disconnect between the patient's day-to-day care or neglect of the marital relationship and his expectation of a functioning marriage point to another problem in his organization of action.
4. His continuation of his suicidal action while he sees the wife panicking and seeing it as something like her punishment is similarly classifiable.

10.2.4 Consciously Prepared or Spontaneously Undertaken?

Behind this question is the idea that the change from a life-oriented project to a suicide project, in which the suicidal action is then carried out, is either executed out in a planned goal-directed way, or happens as a reaction to, for example, the presence of medication, etc. The suicidal action itself, however, is still understood as a goal-directed action, whether it is calculated or emotional. The patient saw himself in a relationship or even life crisis, then had to cry in bed for the first time and pumped himself an overdose of insulin. The patient did not go to bed with the intention of suiciding himself there, but he thought there, took stock of his life, and decided to kill himself. Even though he became very emotional, his suicidal action cannot be understood as a sudden prompting that could not have occurred a few minutes later. The patient pumped himself an insulin overdose for over 45 min, and even the presence of his wife in the bedroom or her despair could not stop him. The decision to overdose on insulin was certainly facilitated by his suicidal experience about ten years earlier, when he tried to commit suicide in the same way.

▶ **Summary**

1. After the patient, in a marriage and life crisis, did not receive the expected concession from his wife, he pumped himself an overdose of insulin in bed. He did not go to bed with the intention of killing himself, but decided to do so only after taking stock of his life, which moved him emotionally. However, it speaks of a persistence in his suicide, because he pumped himself the overdose of insulin for about 45 min regardless of the presence of his wife.
2. The patient had attempted suicide in the same manner about ten years earlier.

10.2.5 Problems of the Action Monitoring Processes

However, in addition to the problems of action organization, the patient would also have to solve the problems of action monitoring that he revealed in his suicidality, his suicidal action. Attention and consciousness, emotion and pain are also processes that show many

deviations in suicidal patients in suicidal actions. Consider one of his statements, "…I had told her (the wife) quite clearly that I now wanted to know what she had done to whom and how. I said that I simply had a right to know. It would be easier for me then, and it would be easier for her because I wouldn't always be asking. That way I would know then. Then this would be completed for me." Monitoring a joint action through communication, like monitoring an individual action through awareness, feeling, and pain, is important for adequate action. While communicating about the wife's infidelity may help shape optimal joint action in the marriage, monitoring the intimate action the wife experienced outside the marriage is not. Here the young man confuses monitoring his own actions with monitoring the wife's actions. It is not only that he wanted to know this, what she had done with the other man, but above all that he could not sleep until he found out. We can also understand how he developed this comprehensive monitoring of his own actions by looking at his statement about his first suicidal action: "When I was 17 years old – or was I only 15 years old… I did the same thing then that I have done now (attempted suicide by insulin overdose). At the time, however, I saved myself of my own volition." We know that in the last suicide attempt he expected others to save him. Did he give up action monitoring of his own actions in this regard for action monitoring of others? Accordingly, he was able to save himself on his own initiative then, which was no longer possible this time. Yet the basic problem with the suicide attempt was comparable. At that time he was denied the expectation of his favorite profession, this time his expectation of the fidelity of his wife was violated. With this issue that the violation of his expectations were experienced as so existentially threatening we can turn to the adequacy of his cognitive-emotional monitoring of this situation. We know that a emotional memory, especially a very painful or existentially threatening one, replaced the present feeling monitoring, which is a problem of action monitoring. The patient reports that he grew up in a family of self-employed people where working and going to work were the first priority. We do not know how intensive his mother's care was and what their relationship was like, but we do know "My parents were self-employed. I had to consider myself lucky if I saw my father briefly on weekends." From this patient's narrative, we can surmise that on the one hand, the patient felt that the professional was very important, and on the other hand, that time with parents was very scarce, which often leads to insecure attachment in young children. With such experiences, people are sometimes later overwhelmed by feelings of rejection and withdrawal of love. One of the young man's suicide attempts related to a violation of a career expectation, and the other occurred after a violation of a relationship expectation. In addition to these problems of action monitoring, there are others, such as certain processes not being mirrored with the appropriate monitoring systems, but other monitoring systems being advanced. A thought is experienced as a feeling or an emotion is experienced as pain. The patient does not report feeling disappointment, but says, "She (his wife) then told me the truth. At first this hurt a lot." "…And I also think that it would not be normal if it did not hurt me. Sure it would be good if I didn't have any pain inside." "…She just did something that wasn't normal and that hurt me. It pained me that she was doing things with him that

she would never have done with me, that she couldn't stand with me." This monitoring problem can lead to internal pain being fought through physical pain, through self-harm or in a suicidal action.

▶ **Summary**

1. The patient mentions problems of consciousness monitoring only in connection with his hypoglycemia, his low blood sugar.
2. He does, however, let us in on his problems of monitoring action when he speaks of his confusion of monitoring joint action and individual action. This is the case when he demands that his wife describe to him everything she did sexually in her extramarital relationship.
3. The experiences that led to his first suicide attempt can be compared with the experiences before his second suicide attempt. The fact that such experiences – violation of his expectations – were experienced as so existentially threatening testifies to a lack of adequacy of his cognitive-emotional monitoring of this situation. The patient mentions that in childhood the time with parents, especially the father, was very limited. With such experiences, some people are later overwhelmed by the feelings of rejection and withdrawal of love. Here the emotional mirroring of the present situation is replaced by an emotional memory.
4. When asked what he was feeling at the moment of the suicide, he replied "Nothing… I just cried the whole time." Not being aware of feelings and not being able to name them is also a testament to his monitoring issues.
5. Certain processes are not mirrored with the corresponding monitoring systems, but are replaced by other monitoring systems. A thought is experienced as a feeling or an emotion is experienced as pain. The patient does not report that he felt disappointment, but says it hurt him. This monitoring problem can lead to the inner pain being combated by physical pain, and that is where self-harm or suicide comes in.

10.2.6 Problems of Action Energization

What problems of energizing action through emotion did the young man have to struggle with? He tells of how he worked on feelings of love in his relationship with his wife the week before his suicidal action, because he felt that this feeling could energize their life together "I then tried to give her (his wife) this love for the duration of a week. If I told her I'd be home at 4:00, that's when I'd be home: at 4:00. Maybe at one point it became 4:05. But it wasn't like before, when I didn't get home until 8:00 each night, and I took work home with me to boot. I never got anything back that whole week. I put all my energy into our relationship." Unfortunately, he assumed a few actions could transform a long relationship overnight: "I always felt like something should come back after all."

The young man also tells of other actions that he energized with strong emotions "I then freaked out quite a bit. Therefore, I drove home in a rage. I then got off at home and simply said that I now didn't want to and couldn't. I told her that I didn't want to see her now." This was not only the case in several exchanges with his wife, but also immediately before his suicidal action. He speaks initially of a sense of uncertainty – "That's right. It was then also the uncertainty which led to this action. It was finally that I was no longer allowed to touch my wife. She always said straight away that I could just never let it go. Then the question always came to me what she had had with the other man. That was simply the point that broke me, that drove me to all this."

"This question led me so far that on Monday night I had to say that I had now accomplished everything, and that I could now go." In addition to the emotions energizing the suicidal action, there was also his disappointment from the hurt expectation of his wife "I always felt at that time that something must and will come now. But nothing ever came. That destroyed me. That then eventually led me to commit this action." His emotions immediately before the suicide action also included his assessment of his state of mind: "I was just so down, so broken, that I said I didn't need to be in this world anymore. That's when I overdosed on insulin units." He details this condition even further "I lay in bed thinking and crying like a castle dog." "I cried for the first time during all this time." "Then when I was crying like that, I just had to tell myself that the smart thing to do was to leave now. My son still had fond memories of me. I had played with him that evening. And everything else is anyway…" "I was in the bedroom at the time. I started pumping insulin". Incidentally, this "crying", this "being knocked down", "being broken" was difficult for the young man to describe in emotion terms. When asked "What did you feel?" he replied "Nothing… I just cried all the time." Not being aware of feelings and not being able to name them makes it difficult to deal with threatening emotions and work through them before they can become destructive to action.

▶ **Summary** One could assume that the patient either energizes rational actions (fulfilling duties, giving and taking, performing something), or then experiences excessive energy surges due to feelings that cannot be dosed.

10.2.7 Suicide and Interactive and Joint Action

We showed that suicide must be seen in its relational aspects, in its relatedness to other people, for effective suicide prevention to succeed. In many cases, as with this young man, this is very obvious. He himself justified his suicide attempt on the basis of disappointed relationship expectations. His brother admonished him that "there was no woman in the world worth giving up his life for." To which the young man replied in the negative, "That's when I told him that wasn't true."

His wife had become sexually unfaithful to him, and his efforts over several days to repair the relationship were to no avail. Moreover, he administered the insulin overdose at home, in

the marital bedroom, when his wife and child were at home. Fortunately, his wife found him very soon, recognized his intentions, and called his parents, sister, and finally successfully called his brother, who was soon able to come and take the suicidal husband to the hospital. Shortly before the suicidal action, the young man had a telephone conversation with his friend or acquaintance who offered him a job in another city. However, this job was not very attractive to the patient, so he was unable to separate himself from his nascent suicidal concern. A far-reaching relationship that the patient described as effective in his suicide attempt was his relationship with his parents. He learned at home that his professional life, his own business, should take first priority in a person's life. "I worked seven days a week, 12 to 15 hours a day. I always said the further up the ladder you go, the more responsibility that you have, the more you have to perform and work. But she couldn't understand that."

He explained the different expectations of family life of him and his wife by the different experiences in the family of origin. He reported that his wife's parents, as employees, could enjoy the end of work already at 5 p.m., while his parents were self-employed entrepreneurs and therefore he could only see his father briefly on Sunday.

At the core of successful joint action is communication that is action-relevant and action-facilitating. In the self-confrontation interview, when the patient was able to engage more with his insights, he elaborated, "I'm sure that was hard for her, too. She never knew whether or not I was expecting anything too. I never told her that she should also approach me a little bit, that if I approached her, that she could then also approach me. I expected that at least just a little bit of all that I had given would come back each time. After all, like doesn't always have to be repaid with like. But I never told her that. I think this is probably the biggest problem with society today. People don't talk to each other. You don't say what you're feeling right now. When you're angry, you don't say you're angry right away. You show it more non-verbally. You just make a face and look angry and sad at the world." The role that joint action and the relationship with his wife might play in the patient's future suicidality is revealed in a reflection he formulates in the closing stages of the interview "He (brother) already asks me if I feel that something like this could happen again. Today I just have to say that in this situation as it prevails at the moment, I wouldn't do it again – definitely not again. But I also have to say that I don't know how I would react if my wife and I didn't get back together. I just don't know what the situation would be then. I don't know how far down I would fall then. I would either say that this is the way it is and life has to go on. Or the world would come crashing down on me. I just have to say here at this point that I don't know how I would react."

► **Summary**

1. The patient's suicide attempt is embedded in the joint action. The patient describes his suicide attempt in close connection with his marital crisis – he suicided in his apartment, where his wife and son were also present.
2. Shortly before his suicide attempt, he was still negotiating with an acquaintance about a new job.

3. During his suicide attempt, his wife called his brother, who then took the patient to the hospital.
4. The patient also mentions the source of the difference in his and his wife's understanding of their professional lives – the example set by their parents. In this respect, the relationship with parents was also an important part of his suicide attempt.

10.2.8 The Young Man's Conversation with a Psychiatrist

The young doctor opened the conversation with a question, in which he also formulated the task of the conversation "I just know that you attempted suicide. But I don't know when that was or how it got that far." In the **1st joint action,** the patient accepts this task and, after a few follow-up questions, gives a detailed account of the critical week he considers crucial to his suicide attempt. He starts with the their Sunday when he became suspicious and stalked his wife, who went to see another man. In a conversation, his wife revealed to him that she no longer had sexual feelings for him. He then made an effort to be there for the family during the week and to spend evenings at home rather than at work. However, his expectations of a concession were disappointed. When an acquaintance offered him a new job, but it did not meet the patient's expectations, he concluded that he was not needed and began to overdose on insulin. In the **2nd joint action,** the patient clarifies with the doctor the week that elapsed between the patient's realization that his wife was having an extramarital affair and his suicide attempt: what thoughts moved the young man, how the couple talked about it, what emotions most burdened the patient, how he was able to work with this burden, and how the family spent the last weekend before the suicide attempt on Monday. Immediately after the phone conversation about the offered job, the patient went to the bedroom, where he then later pumped the insulin overdose. In the **3rd joint action,** the patient reported his conversation with his wife, about the job offer, and the possibility of a change of residence. Such situations existed before, but at present this would provide a new option in solving the marital problem. In the **4th joint action,** the patient describes Monday evening and described the situation and the course of his suicide attempt, how he cried in bed, pumped himself the insulin overdose, what he had to do to provide the required amount of insulin, how his wife discovered him, tried to reach his family by phone and how finally his brother came and took him to the hospital where he was treated accordingly. In the **5th joint action,** the doctor offers the young man the opportunity to address what is still bothering him. The patient then talks about his first suicide attempt in his youth and about the present, in which the burdening problems still exist. With the statement that one must take it day by day, they say goodbye.

► **Summary**

1. In the 1st joint action, the patient describes the critical week before his suicide attempt. From the time he discovered that his wife was having an extramarital

affair to the time of his insulin overdose. In the 2nd action together they clarify details of these events. In the 3rd joint action they go into the patient's negotiation for a new job.

2. In the 4th joint action, the patient describes in detail the actual suicide action and how his brother took him to the hospital.
3. In the 5th joint action, the patient reports on his first suicide attempt in adolescence and also talks about his present situation and plans.

10.2.9 The Self-Confrontation Interview

In the **first segment,** the young man describes his first impression while watching the video of his conversation "It's rumbling inside me. I keep asking myself "why?" and "why?"… I am a very restless person inside. Internally, I relive everything I relate. Now when I put the word "cheating" in my mouth, it just shakes me. The same thing happens when I watch the videotape now."

Even after the patient saw the **2nd segment** of the video recording of the conversation, he said "I feel "screwed"… Everything just keeps coming up in me. It's the same every time I drive by A. and C.'s house. I always see "red" then.". In addition, in the self-confrontation interview he was able to describe his behavior, which he did not mention in the first interview, and of which he is not proud "…She didn't want to tell me… That's when I yelled at her and also had to tell her that she was a coward. I told her that she had now done this "rubbish" and now had to own up to it. I challenged her to be able to give us another chance by doing this. I just yelled at her. But I didn't get physical. I never will. As far as I'm concerned, I'm always in control. I would never hit my wife. But I just yelled at her. I then drove past the construction site at full speed despite evening traffic and everything at A."

Seeing the **3rd segment,** the patient expresses a thought that moves him away from his victimhood and expectations: "…nothing has ever come back from her side. There's just nothing for me to hold on to. But now I also have to say that she can't give anything back at all! She's up to her head in water herself. I think that we just both need to be there for each other together. We need to help each other and give the other person enough time." He connects this in the **4th segment** with the intention to communicate more and better and to express his wishes, because "…I'm sure that was hard for her, too. She never knew if I was expecting something too or not. I never told her that she should also approach me a little bit, that if I approached her, that she could then approach me. I expected that at least just a small part of all that I had given would come back each time. After all, like need not always be repaid with like. But I never told her that."

When he saw this section, he says that he was already feeling better in the conversation than at the beginning "…Here I got the feeling that even if the relationship would no longer come about, that then life would still go on. Here I was also no longer so inwardly…"

"I just had to say that life will go on. Maybe it will go on without my wife. But I have a child. That fact alone is worth enduring life."

In the **5th segment,** the patient elaborates on the topic of the new job that he raised in the conversation with the doctor. He also expected the first session with the marriage counselor to give him advice on whether or not to take the job: "My expectations going into tomorrow's session are that she (the marriage counselor) can tell me if it makes sense for me to go to D. or if it will make things worse." After viewing the **6th segment** in which the patient described the suicidal action, he said "Emotions and feelings come up in me." In addition, he still explained his motivation for the first suicidal action, how he was "very angry at my illness (at the time)." He also informed about his emotions during the suicide attempt "I wasn't scared of what I had done – I was just scared of the uncertainty." He substantiates his determination to die with information about the life-threatening nature of his condition, "…if I had been admitted just half an hour later I wouldn't have made it" as well as his conversation with the brother who came to his aid, "My brother told me that he was now going to drive me to the hospital. But I told him that he knew very well that he could not take me there against my will. I also told him that he must know that he needed five men to carry me out when I was hypoglycaemic. So that's when he told me that he was going to slap me in the face first. And already he was slapping my cheek…". The patient was also able to describe the time after the hospital stay, which he did not find the opportunity to do in the conversation with the doctor.

After the patient also saw the **7th final segment,** he still expressed himself in the sense that it might be better if he took the new job and moved there on his own. It is four hours away by car and they would get the necessary distance.

▶ **Summary**

1. In the self-confrontation interview, the patient is given an opportunity to describe how he felt during the conversation, what he is thinking and feeling now, and what he thinks about the whole thing. He tells how he feels the strong feelings of the suicidal action again in conversation and also in the interview. He also describes the uncontrolled emotional outburst towards his wife (1st and 2nd segment).
2. In the 3rd segment he moves away from his attitude of suffering and sets initial goals about what they should do together. He further specifies that above all they need to communicate better and also hints at an acceptance of the current situation (4th segment).
3. In the 5th segment, the patient formulates his expectations for the marriage counseling that will soon take place.
4. In the 6th segment, he talks about his suicide experiences and his determination to die, as well as his confrontation with his brother who tried to save him.
5. In the 7th and last segment, the patient himself comes to a decision for which he does not need advice. He thinks that taking the job in the distant city would not be a bad idea.

Case 9

11

11.1 Suicide Story: Marie, Who Actually Did This on Purpose

Annette Reissfelder

11.1.1 The Mother

She had loved Mother very much as a child. Of course she forgave her everything, even the fact that she had often hit Marie. She knew it was only because of Father. Whether her mother loved her as much, she wasn't sure. Her mother cared for her, but was still never completely there for her. How typical that she, just like the others, thought Marie ate the broken glass merely because of the botched exam. She hadn't noticed anything at all the whole time… Marie already knew that, being the middle one, there was no attention left for her. All of her mother's energy was absorbed by Petra and Ilonka. But that didn't matter anymore. Today she didn't need anything from her mother. In fact, she didn't even want her to know anything about her. What would there have been to tell?

Even if Mother rarely took her seriously, she was the only one Marie liked to go to town with. Now that Mother had her second job and a boyfriend, she was home even less and hardly ever had time to go into town with her. She hadn't liked Mother demanding that she lie to her father. She was supposed to say Mother was out with a friend when, in truth, she was with her boyfriend. Marie was then alone with Father, each in their own room. Petra was usually with Ilonka, that is, when Ilonka wasn't in trouble with the police or having some issues with her apartment. In which case they were all at home. That was unbearable. If she had passed the exam, she might really have been able to move out. But she hadn't passed it.

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11.1.2 Regula

The person she was most attached to was definitely Regula. They hadn't known each other long, but Marie could trust her. Regula was the only one who she had told that she had eaten pieces of broken glass. Regula had been really worried about Marie, and had even come with her to the hospital when the surgical outpatient clinic hadn't wanted to take her, despite the children. Still, Marie didn't know where she stood with her. After all, Regula was ten years older and had a family. Not only did she have the baby, but she had Max and Betty, and they always took precedence and butted in when Marie was with her and wanted to talk to Regula. That left very little time. Marie liked the children, but she would have preferred to be alone with Regula sometimes. Once she had suggested that they go to the ice cream parlor together. Regula hadn't even answered, but treated her as if she had said something stupid. Marie had felt as if she was at work in the office and had become impatient.

She noticed that she never went out after the office or on weekends these days. Since Regula was now working every other week, she went out still less during the week. Actually, she only went to Regula's once every two weeks. She always looked forward to that for days. How she would have loved to visit Regula every day after the office! She could have helped her with the children, too. But Regula didn't want that.

11.1.3 Vreni

It was much better at the vocational school than at school, if only because of Vreni. Marie's German wasn't that good, so she had to attend remedial classes, but it was nothing in comparison to before, when she was teased because of her foreign accent. Now school was ok. Plus, there were the breaks she could spend with Vreni when Vreni didn't have something to talk about with someone else.

Everyone in the office made fun of her for wearing long sleeves even in the summer. That was just so no one would notice if she cut herself, not because she was cold. Once, when Marie had bandaged her wrist, Vreni had looked quite suspicious during the break. Marie had told everyone that she had sprained her hand. After that, however, she had only cut her legs for a few weeks to be on the safe side.

Vreni was adventurous. Last year they had even gone to Lanzarote together. But it hadn't worked out so well on holiday, because Marie had never managed to say what she wanted to do, and Vreni hadn't felt like deciding everything on her own, especially if Marie said afterwards that she didn't like it. Marie hadn't known how to respond to that, and Vreni had been annoyed. Vreni could be relied upon to bring Marie everything she needed from the town. Then she didn't have to go out among people herself. She didn't like going into town at all, because people stared at her everywhere.

If Vreni hadn't suddenly appeared in the swimming pool on Saturday, she wouldn't have had to give up trying to drown herself. The first attempt had not worked – she had

come to the surface again and again, because she had such a strong urge to cough. Then, when she had seen Vreni, it was clear to her that she had to find a different way. She didn't want to do that to her. Vreni, of all people, had always told her to just believe that she would definitely pass her exam. Then she had believed it herself at some point, and was shocked that it had not been enough.

11.1.4 Ilonka

How could Ilonka have ever thought that Marie was her favorite sister? But she had really said that. Actually, they had gotten along well when they were little, until Marie had been bothered by Ilonka constantly trying to tell her what to do. Since she no longer lived with them, it made Marie absolutely furious. In general it had become more and more difficult to get along with Ilonka, ever since she had started with drugs – already at 16 or 17. She was often in a bad mood when she hadn't smoked anything. And she usually took her moods out on Marie. Later, with the heroin, it became unbearable, it really broke Marie.

The worst thing was when Ilona's friends came and they were all in Marie's room, because there was nowhere else to go in the flat. Mother always locked the living room when she left the house. Marie only had peace and quiet when no one was around. If it weren't so hard to go to town, everything would be easier. What if Ilonka resented Marie for refusing to get involved in her lies and drug stories? She might do…

11.1.5 Petra

Marie often used to quarrel a lot with Petra, but they still got along. When she was smaller, she was a little envious, because as the youngest Petra was allowed to sleep in Mama's room for a long time – her parents had separate bedrooms since she was born. Petra was, in any case, just Mammie's little ray of sunshine. She was funny and sociable and brought her friends home with her. Marie could play with them until Petra started to not want her around anymore. That had been a few years back now, about the time Ilonka had started dragging Petra into her drug stories. Now she didn't envy Petra anymore. Marie had tried to help her, but Petra had only laughed at her. Because of Petra, Mother had started drinking some time ago, and had had two nervous breakdowns. No one knew what to do about Petra. Mother wouldn't say anything about it - except that Marie should stay out of it all. That was probably for the best. If only she wasn't living at home now, it would be easier.

11.1.6 The Father

When she was little, she was afraid of her father. At that time he was still an alcoholic and often came home drunk. She was especially afraid after once seeing him hit her mother in

the face so hard that she got a nosebleed and locked the children in a different room. Mother had suffered greatly because of him, once even taking an overdose of pills. Father had not even let the three of them go to the hospital to visit mother at that time. Today he no longer touched alcohol. But for Marie he still didn't exist. Back then, when she would have needed him, he hadn't been there for her. He had never been interested in her. Now it was too late – she would have to forgive him before she could talk to him. Some chance of that happening!

She hadn't wanted the apprenticeship he'd organized for her then, but Mother had insisted that she take it. So Marie did. The only thing he could have done for her today was to find her spitting up blood after trying to vomit up the broken glass. That's how she'd imagined it, but it hadn't worked out that way. Father was the only one who didn't want her to move out. Maybe that was because he was afraid that if she did, Mother would leave too. Now she was supposed to keep the family together.

11.1.7 The Boss

She had sensed from the beginning that the boss was something better. After all, he had built the company and could oversee everything that happened there. Father had impressed upon her that he had only taken Marie because he had a friend who knew her boss from the army. She sometimes didn't understand what exactly he wanted her to do which made her feel very stupid. Even when she did understand, things usually went wrong. He had no problems with the others and praised them when they brought him something. He had never praised Marie. She always found it harder to concentrate when she was given an assignment. The fear that she would make another mistake was there immediately. A few times the boss had become really furious.

Now that she had failed the exam, her first thought was that there was no way she was going to the office on Monday. But when Monday came and she didn't feel bad enough to stay at home, even though she had eaten from the broken glass pieces a second time, the boss immediately suggested that she should look for a new job instead of letting het repeat the year with him. He hadn't even offered the option, which depressed her greatly. He obviously wanted nothing more to do with her.

11.1.8 The Boyfriend

Her boyfriend had always said she was the only one who was normal in her family. He had also encouraged her to talk about her feelings – not to keep it all bottled up. But she just hadn't been able to. You just couldn't talk about these sort of things. But then things couldn't go on like this either.

11.2 Suicide Analysis: I Actually Did This on Purpose

Ladislav Valach

The psychiatrist asks the petite young woman, "Now can you tell me what led to you being in the hospital in the first place, what were the circumstances?" And the woman describes how, after an unsatisfactory report card and the threat of losing her job, she didn't want to come to work on Monday. She tried to drown in the pool, then tried to cut herself with broken glass and finally swallowed the broken glass from a picture frame.

11.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

11.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

What at first looks like a reaction to insufficient grades in the report card and an avoidance of the negative experience (quitting an apprenticeship), is revealed in the conversation with the young woman to be embedded in a series of comprehensive, longer-lasting processes and concerns of the woman. She struggled for a long time with great self-uncertainty and fears, cut her arms and legs for several years, tried to save her sisters from drug addiction, struggled for the love and attention of her parents, wished to die for a long time, felt neglected by an acquaintance and many other things.

11.2.1.2 Long-Term Concerns

The young woman tells of her father's previous alcoholism, who was violent towards her mother and paid no attention to the patient: "When I was little I was always told no not told… anyway I always felt that I was not liked." "Winning the love of her parents" was certainly an important long-term concern for the young woman. However, she now rejects the father because, "I needed their love as a child and now I don't need it." The patient was given a younger sister and from that moment felt excluded from her mother's love: "The younger sister was in the same room with my mother for a very long time and I was like an outcast." She felt her long-term concern of receiving love and attention from her parents was unfulfilled. She also found her competencies of acquiring age-appropriate self-confidence and independence unachieved "My mother also used to tell me to go shopping, which I couldn't, also because of the self-confidence that had been broken. Because of that, I could never go shopping, to which I always heard that I was stupid, that I couldn't do anything." The effort "to have self-confidence" shaped the patient's actions.

The concern to "do well compared to other people" also fell by the wayside: "…other people are better than me… from thinking that they are more intelligent or yes, that they can do something and I can't." Unable to achieve these aspired states and processes, she became anxious and ashamed of herself in front of other people.

11.2.1.3 Medium-Term Concerns – "Projects"

After the patient's younger sister also became addicted to drugs, the patient's mother began to drink. The young woman wished to escape the unsatisfactory situation at home, where the father was violent towards the mother and the mother attempted suicide: "...I wanted...an "own apartment", "a child", "a family", "to be able to drive a car" and also "to achieve something...professionally"…" She wanted to "complete an apprenticeship", "maintain friendly relationships", "find understanding and interest in others", help her "younger sister out of drug addiction". To do this, she struggled with her fears, her sense of shame, her fear of not being seen as "normal" because she had been cutting her arm for five years, which she carefully tried to hide by wearing long-sleeved sweaters even in the summer.

▶ **Summary**

1. The patient describes some long-term concerns that she could not achieve and therefore wanted to leave life. She wanted to "win the love of her parents", "not be rejected by her mother", have more "self-confidence" and "do well compared to other people".
2. The problems with these long-term concerns also influenced, in her view, her poor performance on a range of medium-term concerns such as "having a place of her own", "having a child", "having a family", "being able to drive a car" and also "achieving… something… professionally…" She wanted to "complete an apprenticeship", "maintain friendly relationships", "find understanding and interest in others", help her "younger sister out of drug addiction".

11.2.2 Short-Term Actions in the Self-Punishment Project

11.2.2.1 Short-Term Actions in the Suicide Project

Suicidal Action; Patient (P)

Cognition P: I actually did that on purpose. …

Suicide Initiation

Cognition P: I found out on Friday that I failed the final exam,
Cognition P: whereas I was fully convinced that I could do it.
Cognition P: Afterwards, I just couldn't go to work the next Monday,
Cognition P: because my boss had already approached me half a year before about my report card grades and said whether this (employment?) should be terminated.
Cognition P: Then I thought to myself that I had to do something so that I wouldn't have to leave.

Suicidal Action "Drowning"

Action P: So I went for a swim on Saturday…

Cognition P: and thought about drowning myself there, meaning drowning, just diving and then breathing in the water.

Action P: However, I did not succeed in doing that then.

Cognition P: I do not know why, in any case, the courage has left me.

Suicide Action "Slashing the Wrist"

Action P: On Sunday evening before I went to sleep, I was alone in my room, actually alone at home, and there I saw the picture frame that I had left lying around on Friday and it had just broken, maybe because it had been lying there and someone had stepped on it or I don't know what.

Action P: Afterwards I saw the glass and tried to slit my wrists, but I had tried that many times before and it never worked.

Suicide Action "Glass Swallowing"

Action P: That's when I tried to swallow the glass.

Cognition P: I didn't know that this could have such dire consequences. I only found out later.

Sensation P: Anyway, I had a feeling that I might vomit, possibly vomit some more blood, so I would be hospitalized and thus not have to go to work on Monday.

Joint Action "Conversation with Boss"; Patient (P), Boss (Ch)

Action P: Monday morning I went to work anyway because nothing had happened.

Sensation P: Anyway, I felt bad, maybe because of the imagination or psychically. I felt the taste of glass and also had a stomach ache.

Joint Action P, Ch: At work I had a conversation with the boss,

Feeling P: which depressed me a lot,

Action Ch: because he told me to write applications and I couldn't stay with them.

Action P: That's when I asked if I could leave because I wasn't feeling well.

Joint Action "Girlfriend and Hospital Visit"; Patient (P), Girlfriend (F)

Action P: Then I went to see my best friend

Action P: and told her that I had done shit, that I had swallowed glass and what now.

Action F: She said we should go to the clinic because it was closest.

Cognition F: But then it occurred to her that this hospital was only surgical, that it had nothing to do with internal medicine at all.

Joint Action F, P: Then we called another doctor, an intestinal specialist, and he then said that we should go to the hospital on an emergency basis.

Joint Action F, P: But we didn't want that, which is why we called another (doctor) and he said exactly the same thing.

Joint Action F, P: Then we just came here at noon.

Suicide Cognition, Patient (P)

Cognition P: (Was it my) intention … to kill me?

Cognition P: I can't say exactly.

Cognition P: When you're in a hole like that, you don't care and somehow you don't want to die because you don't know what to expect or that you'll miss your best friend and think that can't be all. To die and then leave her alone… she's actually the only person I'm still sort of living for.

Cognition P: I think that also has to do with pity, that you want that, because I'm the middle one and whenever we had a fight among ourselves, I was the guilty one.

Cognition P: When I was little, I was always told no not told… anyway, I always felt like I wasn't liked.

Cognition P: The younger sister was in a room with my mother for a very long time and I was like an outcast.

Action Mother: My mother also used to tell me to go shopping,

Cognition P: which I couldn't do, also because of the self-confidence that had been broken.

Cognition P: Because of that I could never go shopping, whereupon I always heard that I was stupid, that I couldn't do anything.

Cognition P: And with the triggers that I've done now. Maybe that was because I wanted to see if there was anybody else that… for me kind of, if anybody still liked me.

Relationships with Family, Girlfriend

Cognition P: (I'm not quite sure if they like me in the family). And also with my best friend… so I like her a lot, but I don't know how much she likes me as a friend. She has three more kids so she doesn't have as much time for me and she started a new job and then I see her one week and don't see her one week.

Cognition P: I never wanted them (family) to know that (that I was suffering).

Cognition P: They only found out now when I swallowed the glass and was in the hospital. But they think it was because of the final exams, but they don't know that I wanted to take my life before that. And I don't want them to know that either.

Cognition P: For what. I would have needed her love as a child and now I don't need it anymore.

Cognition P: That (a bit of defiance) can also be.

"Cutting Yourself"

Cognition P: I was never asked about it (cutting) or I wore long sweaters even in the summer so that you don't see it.

Cognition P: Also at work always wearing a long sweater, even in the summer and they told me there if I didn't want to put on another jacket. But I didn't really care.

Action P: Sometimes I also put a bandage on it when it was fresh

Joint Action P, workmates: and afterwards they asked me what happened and I answered that it was just a little sprained or burned.

Cognition P: Anyway, I could also make up the fantasy… just make it up and say something happened.

Cognition P: Yes. (It's very much a contradiction. On the one hand I wanted to arouse pity and on the other hand I don't need the love at all).
Cognition P: Why not share everything? Maybe out of fear that if they saw it, they would say I'm really crazy.

"Psychotherapeutic Treatment"
Action Doctors: I was also told if I shouldn't go to the psychiatric hospital… that is, if I should go home or if I should go to the psychiatric hospital.
Cognition P: That also frightened me, because if you have problems, you are just deported as if you were really stupid. And when you talk about the psychiatric clinic outside, they always say that only the crazy ones are there.
Cognition P: (There is no one who could understand me. I feel that there is no one who has positive feelings for me).

"Destructive Actions"
Cognition P: Ever since I was very little – I never thought of murder, of murdering myself or anything – but I know I cut the skin off my arm with scissors.
Cognition P: I don't know why you do that, but maybe it's because you hate yourself and you think you're stupid and you couldn't achieve something. You just hate yourself and break yourself down that way. It's not just on your arms either, it's on your legs as well.
Cognition P: (I hated myself).
Cognition P: About five years ago (I started cutting myself).
Cognition P: (I hated about myself) just that I had no self-confidence, that I couldn't go shopping by myself or go to town by myself or that I couldn't do anything.
Cognition P: (I couldn't because I was) afraid (of it).
Cognition P: I was ashamed in front of people, the way they looked at me.
Cognition P: I still feel today that the other people are better than me.
Cognition P: Also from thinking that they are more intelligent or yes, that they can do something and I cannot.
Cognition P: It's also like both my sisters crashed and that's when they (the parents) had grief too and had to deal with them a lot. The mother also had nervous breakdowns because of the two of them and they kind of forgot about me.
Cognition P: It's also the case that I wanted to help the younger sister to get out of it and I never found the strength to do it myself, because if she didn't want to, then it wouldn't work.
Cognition P: The older one has been a drug addict for a long time and then she dragged the younger one into it.
Cognition P: And the mother doesn't know how to help either. I've told her a 100 times that if anything she should take her home and leave her here instead of leaving her with them because she (the older sister) has a place of her own. What also breaks me is when the older sister is with us because she is always in a bad mood due to the drugs and takes it out on me.

“Hyperventilating”

Sensation P: I have trouble breathing.

Cognition P: I’ve had that for about a week now, but they also told me it was because I didn’t have enough iron in my blood and that the blood would also carry oxygen… because of that somehow.

Cognition P: That’s maybe because of the excitement or because I’m nervous.

Cognition P: Well, it also annoys me because I don’t have enough air in my lungs and I have to breathe in like this.

Cognition P: (It’s a kind of constriction in the chest).

“Communication at Home”

Cognition P: Mother goes out very late in the evening and drinks, but only since the

Little one (sister) got involved because she doesn’t know how to help either. And the father… I don’t know why they didn’t do anything.

Action P: I’ve told the mother a 100 times to do something.

Mother’s action: Then she cheekily told me not to interfere, that was her business.

Cognition P: I’m actually talking… even as a small child I was afraid of him (father). I don’t know why I was afraid of him either. Anyway, I didn’t talk to him. Even when I was little, I never went to ask him anything, was always alone. I don’t talk to him now either, because somehow I would have to forgive him so I could talk to him.

Cognition P: He used to be an alcoholic, which he is no longer. He doesn’t drink alcohol anymore today. Maybe we were afraid of him when he used to come home drunk.

Cognition P: … there’s a picture that shows how mean he was that I remember very strongly: he once slapped my mother over a little thing, who had a nosebleed afterwards. That was the end of the matter. Afterwards he locked us in the room so that we wouldn’t notice anything. Then I saw how much she suffered under him. She also tried to kill herself once and took pills and drank alcohol, after which she was hospitalized. We were not even allowed to visit her and were not allowed to find out what had happened and were locked in the room again.

“Suicidal Ideation”

Cognition P: It’s just a lot of things coming at me or came at me, better said that I told myself that I couldn’t take it anymore, that it was enough.

Cognition P: (I can no longer, means then I do something to myself).

Cognition P: It was very common. Anyway, there again I felt like a loser because nothing ever really worked out.

Cognition P: Because maybe I hadn’t managed to take my life.

Cognition P: I don’t care about anything. You think about what you could do to make it … yeah, easy too. How do I explain it. When you have pain in you psychologically.

Cognition P: Nothing matters. You have only one way out and you try everything you have, all the possibilities. You’re like in a hole, everything is black. You don’t see anything colorful in your life anymore.

Cognition P: Yes, but when you're in the hole, like I say to that, you don't really have… At the moment when you're doing something, like slitting your wrists, then you don't have any fear, but afterwards when the blood comes it stops, you can't do that. Now you have to think, otherwise you'll end up on the other side of life.

Cognition P: I was often hurt, even as a child. Then I was also afraid to open up in front of anyone and say that.

Cognition P: I also had a best friend and then she fucked me over too… so yeah.

Cognition P: And then she is still not there when you need her.

Cognition P: That (I'm not worth as much as the others) probably also became that way because of society, so because of the people who thought they were something better than me.

"Failures in Life"

Cognition P: I have achieved nothing at all in that sense, when I think about what I wanted until now.

Cognition P: What I wanted. An apartment of my own, a child, a family, being able to drive a car, and also what I wanted to achieve professionally, I didn't manage. I still have time, that's true.

Cognition P: (I want to become professionally:) a baby nurse, but that would have been very difficult for me. And what I would have liked to become is a policewoman, maybe to create order on the streets and also to ban drugs, just ban everything that goes on behind our backs.

Cognition P: (I can't manage it) Because of school, further education, because I also think it's difficult for me. Also these thoughts with the "hole" don't give me the hope that I could concentrate on something.

Cognition P: (I can't overcome that) Because, for example, I notice that I have a weakness there when I have to do something for the boss. If I have to decide according to my feeling, then it always, always comes wrong when I have to bring him something. There I see that I can't stick to my thoughts because it always comes out wrong.

Cognition P: If I have to copy sheets for him and he wants two copies each and I only copy one, he gets mad. Or once I had to find a phone number for him and I couldn't do that either because… it's weird. Probably because I'm not that good at German and didn't know how to spell it so I couldn't find it.

Cognition P: then I had to ask again and he got angry because I couldn't even find a phone number that he had already given me the name and location of.

Action P: I usually go crying in the toilet so no one sees me.

Cognition P: It might not be bad if the mistake only happened to me once, but it happens to me every time. And maybe also the fear when he gives me something to do, that I then make mistakes because of the fear.

Cognition P: I don't know how to achieve that (eliminate fear).

Cognition P: The fear also comes maybe also because I have the feeling that he is something better than me and therefore I have to do everything right and I try to see if I am anything (worth) at all.
Cognition P: Not better, but so I can assess where I'm at because, after all, he's the head honcho and he owns the company.
Cognition P: Yes, so because it's his own and who built it and he has power over the people who work there.
Cognition P: I just don't know where I stand with her (girlfriend) either because I, I really like her. And sometimes when I go to her, she doesn't talk to me that much because the kids come first. When she found out about the broken pieces, the first thing she told me was that I was crazy and that she could never do something like that. Just again… yeah.
Cognition P: She didn't mean it as an accusation, but out of fear for me she said that I was crazy… yes; it could have been dangerous.

"Relationship with Girlfriend"
Cognition P: This friend has three children ….
Cognition P: She just had the first, eh no, not the first, the bébé a year ago, so the last child. Her godchild went to school with my little sister. And I also met this girl and because she knew that I like children, she said I should visit her aunt because she had a child.
Action P: Afterwards I visited her once, not alone, because I couldn't even do that, but with another friend whom I had also met. Afterwards we went to her place and I was allowed to hold the baby in my arms.
Joint Action girlfriend, P: You also notice that she wants to help and she talked to me. That evening she just talked to me too and
Action P: I then told her about my scratches that I had inflicted on myself. And through that, that I could talk to her, I grew fond of her and because of that I went to her almost every day.
Cognition P: I think the kids like me because the one, I think he turned eight this year, sometimes calls me to ask me to come play with him. And that makes me happy when I can bring joy to a child by going to play with him.
Cognition P: I just enjoy children and if anything else gives me joy… not necessarily.
Cognition P: So, nothing else comes to mind.

"Sisters at Home"
Cognition P: Somehow I'm also glad that I was allowed to go outside yesterday, that I was allowed to go outside and I wasn't locked up anymore. So locked up I wasn't, actually. And sometimes I think it's a shame it didn't come out worse.
Cognition P: Because now I'm sent home again and the two sisters are home and they're not going.
Cognition P: I asked the mother why she didn't send her home and….

Cognition P: She (sister) has a flat herself, but she has a power cut or something and that's why she's with us now. During the day my parents work and then they still take their friends home. And there's only one TV in my room because they're not allowed in the living room. It's locked when my mom goes to work.
Action P, sister, friends of the sister: Then I'm just with them and their friends and when she's angry she screams all over the flat and so I just can't be at home.
Cognition P: I don't know why either, but no… and also last night I couldn't sleep because the mother still put them in my room. And I couldn't sleep the whole night, anyway they were talking together the whole evening and
Action P: I then told them to go, go home, I wanted my rest and wanted to sleep.
Action Sisters: There was silence for five minutes and then they spoke to each other again.
Cognition P: If I had managed the apprenticeship, I thought about moving out of home if I had a job. I would definitely look for one if I had completed the apprenticeship.

"Exams in School"
Cognition P: I also think that it's (failed the apprenticeship) related to these problems, that because of that I kind of… I think that the thoughts that I wanted to kill myself are to blame for that.
Cognition P: I also used to tell myself at the beginning that I would not pass the exam.
Girlfriend action: Girlfriend told me not to think negative, to think positive, that I can do it.
Cognition P: Two weeks before the exam I thought that I absolutely had to pass the exam, for myself and also to prove to the others that I could do something. And then I believed that I would make it and then this shock when I found out that it was not enough.
Cognition P: Yeah, so the overall average would be sufficient, but I have too many failing grades. You're allowed to have two and I have four.
Cognition P: The subjects I was bad at, I also studied and there I didn't have any unsatisfactory marks during the exam.
Cognition P: I can do another year now, but not until I get a job to repeat the year.
Cognition P: (Which is not yet in prospect) Exactly, that's what depressed me when I went to the boss's office and he told me to write applications.

"Professional Future"
Action P-: (I haven't) applied (anywhere) yet.
Cognition P: (I'm confident I'll tackle this) because I still don't want the two years to have been for nothing, otherwise I'll have to do another two years and otherwise I'd have gained a year.
Cognition P: Now I just have to do one more year.
Cognition P: I think it (treatment) is good because … I'm getting tired of these thoughts and still nothing is happening. And somehow I want help to get over all that, over the things. ◄

► **Summary**

1. The patient describes many actions from different areas of her actions, which represent parts of her projects. She tells about her "suicide action", the "suicide action occasion", about her "suicide action by drowning", "suicide action by cutting the wrist" and then about the last "suicide action by swallowing glass".
2. She talks about actions such as the "conversation with boss", her "girlfriend and hospital visit", "suicidal cognition", actions in "relationships with family", actions with "girlfriend", her "cutting herself", her "psychotherapeutic treatment", her "destructive actions", explains her "hyperventilating" during the interview, tells about "communication at home", "suicidal thoughts", her "failures in life", her "relationship with girlfriend", describes her "effort for and with sisters" at home, her failed "exams at school" and her uncertain "professional future". ◄

11.2.3 Problems of Action Organization

In her narrative, the young woman reveals a series of problems that we call inadequacies in the organization of action. They are problems within the action, problems in the organization of projects and long-term concerns, as well as problems in the organization of the relationships between these processes. We recall, an action is organized on several levels of action, which are related to each other in relations of a hierarchical system. Similar is true for projects and long-term life concerns. Each action takes place with a goal (top level of action organization), in action steps (middle level of action organization) and in individual movements (lowest level of action organization). Each action can be assigned to several projects (e.g., compatible, i.e., matching, complementary, or conflicting projects). In addition, goals and objectives are organized hierarchically. The young woman learned of her failed exams before the weekend and related this to being told by her supervisor that she would have to find another company if she did not pass the exams. Thus, if she went to work after the weekend, she would have to accept her boss's termination in a conversation with him. However, it was important to the patient to complete her training, and she therefore wanted to avoid the situation where he would find out. This concern in itself evidences a confusion in the hierarchical order of goals. The known connections between failing the exams and ending employment and the consequences of failing the exams are not undone by avoiding the situation in which the supervisor confirms that this "if-then" has occurred. At best, the young woman can emotionally protect herself from having to listen to this rejection. The concern to "protect herself emotionally" becomes more important to her than other rational concerns, such as "abiding by the rules of the employment contract" and "not bringing about additional negative consequences." However, this concern also played a role in her subsequent actions. Rather than simply staying away from work, she sought compelling reasons to escape the charge of this rule violation. She tried to drown herself in the swimming pool, but was unsuccessful. I.e., on the level of action regulation, her courses of action functioned in the sense of the overarching goal of "life preservation". Thus, she did not succeed in eliminating it. Moreover, the goal of "dying"

to avoid confrontation with her supervisor is completely inappropriate and irrational, because the patient would not be able to feel the emotional relief of avoiding the conversation, since she would not experience it. A rational consideration was made by the patient when she discarded the option of suicide by cutting her arm, as she had already had disappointing experiences with this. She tried to achieve her goal by swallowing broken glass. Here she revealed a certain ambivalence towards her suicidal intention, saying "I didn't know that this could have such bad consequences. I only found out later… Anyway, I felt that I might vomit, possibly vomit some more blood, so I would go to hospital and so I wouldn't have to go to work on Monday." Here she reports a change of goal – no longer wanting to die, but just being ill so she wouldn't have to go to work. In doing so, she later reports that it was an uninformed choice of means, as she could endanger herself by swallowing broken glass more than she intended. The young woman also reported other problems that we recognize as problems in the organization of action. It is understandable that she wanted attention, love and affection from her father. He, however, suffered from alcoholism when she was young and she witnessed him beating her mother bloody. Due to his unpredictable behavior when drunk and his aggressiveness, the patient became afraid of him, so she did not dare to approach him. Now she rejects him even though he no longer drinks. She defiantly reports that she does not want his love now because she did not get it when she needed it, but she lets it be known that she would also like his approval. She is afraid of him and probably of authority figures in general. She carries a conflictual attitude toward him and possibly other authority figures. With this cognitive-emotional condition, the young woman's capacity to act is greatly diminished. She describes these experiences as follows "… I (have) a weakness there when I have to do something for the boss. If I have to decide according to my feeling, then it always, always comes wrong when I have to bring him something. That's where I see that I can't stick to my thoughts because it always comes out wrong… If I have to copy sheets for him and he wants one copy of each twice and I only copy one, he gets mad. Or one time I had to track down a phone number for him and I couldn't do that either because… it's weird. Probably because I'm not that good at German and I didn't know how to spell it and so I couldn't find it… then I had to ask again and he got angry because I couldn't even find a phone number of which he had already given me the name and the locality." In these cases, too, the individual concerns of "controlling anxiety," "protecting oneself from the authority figure," "not embarrassing oneself," "not disappointing the authority figure," "hiding one's weaknesses" get in the way of performing the simple task and the young woman does it incorrectly. Her superior is completely overwhelmed by these mistakes and reacts accordingly with anger and incomprehension, whereupon the young woman breaks down ("I usually go crying into the toilet so that no one sees me").

The patient is then confirmed in her assumptions and intensifies her "bias" even more in the next task. An action challenge that could be regulated at the lowest level of action organization will not only affect action control at the next higher level, but may also shape action goals at the highest level of action organization.

▶ **Summary**

1. The patient describes in detail two incidents that reveal her problems in organizing her actions in certain situations. First, there is the problem of the hierarchy of goals. After the failed exam, the patient wants to avoid an emotionally threatening situation, namely the termination interview with her boss. To this end, she deliberates and attempts a suicidal action to avoid having to experience this. When she does not succeed in this, she wants to take at least one destructive action with an unintended goal but still a possible outcome – suicide. A hierarchy of goals would be obvious, such as "stay alive", "protect health", "seek new opportunities in vocational training", "protect herself emotionally in the termination interview".
2. Another problem in the order of action is evident from her relationship with her father and other authority figures. She is afraid of her father, who had alcohol problems and was violent. Now she rejects him even though she misses his approval. Because of this experience, she experiences anxiety and stress when interacting with authority figures, such as her supervisor, and therefore cannot fully develop her abilities and makes many mistakes. Thus, the regulation level influences the management and control of her actions in an unfavorable way.

11.2.4 Consciously Prepared or Spontaneously Undertaken?

The young woman addresses this question herself: "I actually did it on purpose…". However, she is less sure of this than she initially leads us to believe. In response to the psychiatrist's later question as to whether it was her intention to kill herself, she says: "I can't say exactly… When you're in a hole like that, you don't care and somehow you don't want to die either, because you don't know what to expect or that you'll then miss your best friend and think that can't be all. To die and then leave her alone… she's really the only person I'm still sort of living for." She thus addresses precisely the problem of action organization in terms of the relationship of the suicide action to other projects and life concerns. The suicide action was conscious in its goal of action, but the relationship of that action to other projects and long-term concerns was not consciously reflected upon. The search for the appropriate means for the suicidal action (drowning, cutting blood vessels with glass, swallowing broken glass) is evidence of the persistent pursuit of the goal. The goal was thus not initiated by the presence of the appropriate means.

▶ **Summary** Although the patient states a firm intention to die for her destructive action, she later expresses some ambivalence toward this goal. However, the patient considered her destructive action in advance and purposefully sought the result. She sought only the appropriate means, but was not motivated to act by the presence of the suicidal means. The suicidal action was derived from the suicide project (top down). The suicide project was not elicited with the presence of the suicide means (bottom-up).

11.2.5 Problems of the Action Monitoring Processes

What problems did the young woman experience in consciousness or attention processes, emotions and pain in her action monitoring function? The patient not only reports these processes as she experienced them, but formulates her statement as generally valid. She considers the psychic pain as crucial "…When you have psychic pain in you… Nothing matters. You only have one way out and you try everything you have, all the possibilities." We recall, the patient cut her forearm and thighs and found relief, not warning pain. Moreover, warning emotions, such as fear of the consequences of one's actions, do not become salient either "The moment you do something, like slitting your wrists, then you're not afraid…" Only cognitive monitoring enables the patient to become aware of her actions "… but afterwards when the blood comes it stops, you can't do that. Now you have to think, otherwise you get to the other side of life." Where the other side of life means death. If we connect the emotional experience with colors, then the young woman's statement, "You're like in a hole, everything is black. You don't see anything colorful in your life anymore" can be seen as a failure of emotional monitoring. The problems of the patient's emotional monitoring of action were not limited to the absence of colors, but also confused memories of fear with reflections of the present situation. She encounters the father, who no longer drinks, with the same fears as when he acted unruly in his drunkenness at home. She sees the male supervisor with these memories of fear of the authority figure, the father. She emotionally mirrors the tasks assigned to her at work by her supervisor with the experience of past and future failure, so that she cannot perform them successfully. In the actual suicidal situation, she is so overwhelmed by the fear of meeting her superior that she blocks out the majority of the monitoring in the suicidal action. Her intention to drown herself only fails because the unconscious mechanisms of action did not allow her to sink in the water and take it into her lungs. It would require actions that would override these mechanisms, such as, weights that would not allow one to surface, bound hands and feet that would make swimming impossible, not being able to swim, or swimming very far out to sea so that the current would not allow one to return. When considering cutting her wrists with glass, she recalled past failures of cutting with glass, i.e., she considers that these means are not appropriate for her goal of suicide, but cannot consider that her means of suicide are not appropriate for experiencing Monday in an emotionally positive way. In her narrative, the patient describes that she experienced problems with action monitoring not only in the suicide situation, but that she already knew such problems from other situations and that they made her everyday life difficult.

▶ **Summary**

1. The patient reports problems of action monitoring in all domains, consciousness or attention, emotions and pain.
2. Her monitoring through pain stops when she experiences psychological pain.
3. Her monitoring by emotion fails because it is replaced by emotional memories.
4. Her attention is massively reduced by her fears.

11.2.6 Problems of Action Energization

The patient describes her suicidal action as an undertaking that she approached with determination and energy. However, she described many situations that she tried to avoid and did not feel she had enough energy to deal with. In addition, she described moments when she felt like she was in a hole. We can see this as a representation of a situation where the energy needed to act far exceeds the energy felt.

▶ **Summary** The patient mainly energizes actions of avoidance. This energy is missing for shaping everyday life because it is held back by fear and a lack of self-confidence, or is not generated.

11.2.7 Suicide and Interactive and Joint Action

Even though the young woman was alone when she swallowed the broken glass, acting with others is important for understanding her suicidal action. She wanted to avoid the encounter with her supervisor, which she cited as her immediate suicidal motivation. After swallowing the broken glass and withdrawing from work the next day, she went to tell her friend. The latter arranged for both of them to go to the hospital. Of this person, the young woman says "…she's really the only person I sort of, so to speak, live for". Even though she complains that this woman with three children has less time for her than the patient would like. Other relationships and joint actions are fraught with more contradictions, failures and conflicts. The young woman feels that her request, "that she be liked" was repeatedly disappointed. Her mother kept the patient's younger sister with her for a long time and the patient felt abandoned. The father drank and was violent when she was young, and she found no access to him. She could not satisfactorily complete tasks she was given by her parents and later at work because of her fears and as a result she experienced rejection and disdain. Both her elder and younger sister are drug addicts and the young woman experiences the relationship with them as stressful. The older one does not take into account the patient's rights, demands and wishes, and with the younger one, whom the patient wants to get out of drug addiction, the patient experiences only failures. How important relationships and joint action with others are to the patient, we also learn from her narration about her relationship with children: "I think that the children like me, because the one, I think he turned eight this year, sometimes calls me to ask if I can come and play with him. And that pleases me when I can bring joy to a child by going to play with them… I just enjoy children and whether anything else brings me joy… not necessarily… So, nothing else comes to mind." This also emerges from her life goals "…I wanted… a child, a family… (professionally)… baby nurse… And what else I would have liked to be is a policewoman…".

▶ **Summary**

1. Relationships were the be-all and end-all for the patient, she said, and she even risked her life for fear of an encounter.
2. She describes her relationship with a friend as the only thing she still lives for.
3. She describes the relationships in the family as failed or destructive. She felt rejected by her mother, she was afraid of her father, her drug-addicted sisters are either inconsiderate or let all the patient's efforts to help them come to nothing.

11.2.8 The Young Woman's Conversation with a Psychiatrist

After announcing the task of the interview to the young woman, the psychiatrist initiated the **first joint action** by asking "Now can you tell me what led you to end up in the hospital in the first place, what were the circumstances?" In this action, the patient describes in almost 500 words the situation in which she developed her suicidal intent, made several attempts to commit suicide, swallowed the broken glass, heard the bad news from her supervisor that she would have to find a new job, and then finally went to the hospital with her friend. The psychiatrist then inquired if it was really her intention to die and after further explanation from the patient, he summarized it as a back-and-forth, as being torn. The young woman then offers a goal of her suicide attempt as "…pity… that one wants," "… maybe that was… because I wanted to see if there was anyone left who… for me somehow… if anyone still liked me." The patient is very moved by this statement, which the psychiatrist also notes. They then turn to the question of whether anyone liked the young woman, in her family, her best friend, and whether the patient was able to talk about how she suffered with anyone. The patient was dismissive of her parents, saying, "I needed their love as a child and now I don't need it." Thus, she had not confided her earlier suicidal attempts and thoughts to her parents. She also always tried to conceal the consequences of her cutting. The psychiatrist tries to address the contradictions of the young woman – she is looking for pity and love, but does not want to communicate, which she affirms. She feels that there is no one who has positive feelings for her and that this has been the case since childhood. As a result, she hated herself and about five years ago cut off the skin on her upper arm and legs. She was so ashamed in front of other people that she couldn't leave the house alone. She thought other people were much better than her. The young woman also felt forgotten by her parents because they had to deal with her sisters as they became drug addicts.

The psychiatrist introduces the **second joint action** with the observation that the patient always breathes in very strongly. She thinks it could be because of agitation, but she does not know what is upsetting her.

In the **third joint action,** the psychiatrist revisits the theme of the parents being overwhelmed by the sisters' drug addiction. They then come to talk about the patient's father and the young woman describes her fears of him, how he used to drink and beat the mother, and how the mother wanted to commit suicide.

The psychiatrist opens the **fourth joint action** with his reflections on the situation of the patient's family and the position of the young woman in this constellation. He draws attention to the fact that the patient was the only one who worked to improve the family situation. The young woman reveals that her suicide attempt was actually in response to this hopeless family situation. The psychiatrist then tries to help her describe her feelings, which she does aptly.

The psychiatrist begins the **fifth joint action** by asking if the young woman has ever experienced anyone in her life "who could give her more warmth or more understanding?" She then tells of her best friend by whom she felt betrayed. The psychiatrist then wants to confront the young woman with the contradiction that on the one hand she feels everyone else is better than her, and on the other hand she has already accomplished quite a bit despite being only 19 years old. However, she expresses skepticism that she will be able to achieve her life and career goals. This is because she cannot concentrate and she describes how her self-deprecating thoughts and fears prevent her from performing her actions according to her desires and abilities. The psychiatrist then asks her to think about this and do something about it.

In the **sixth joint action,** the psychiatrist follows up on the information that the young woman had found a lot of understanding with the young mother who became her friend. The patient then describes their relationship and how it came about and developed. They then talk about the young mother's children and how the patient feels accepted and loved by the children and that the relationship with children is actually her only joy in life.

The psychiatrist's question "Where does it go from here?" initiates the **seventh joint action**. The patient reports her concerns about going back home because her sisters are there and make life difficult for the patient.

The psychiatrist would like to clarify the patient's professional future in the **eighth joint action.** She describes her career and training options, but is very reluctant to take the necessary steps.

In the last, the **ninth joint action,** they discuss a psychotherapeutic treatment for the patient, to which the psychiatrist wants to motivate her.

▶ **Summary**

1. In the first joint action, in which they agree on the interview task, the patient tells of her suicidal intention, her attempts to commit suicide, how she swallowed the broken glass, accepted her termination and went to the hospital with her friend. When she is then confronted with her suicidal intention, she shows great emotion and says that she actually wanted to check whether anyone still liked her. She speaks of her disappointment in her parents, whom she now dislikes, of how she has been cutting herself for 5 years, and has no one to whom she can have positive feelings. She feels ashamed, forgotten and inferior. In the second joint action, they discuss the patient's hyperventilation-like breathing, which she shows in agitation. In the third joint action, the patient talks about her father and her fears of him.

2. In the fourth joint action, she expresses her insight that her suicide attempt is actually to be understood as a response to the hopeless family situation. She is unable to accept the psychiatrist's praise in the fifth joint action because she believes that she cannot achieve professional success because of her fears. However, in the sixth joint action, she is able to reflect on her positive relationship with a mother and her children, by whom she feels loved. In the seventh joint action she comes to talk about her future, which she is very skeptical about. She has misgivings about going home and resuming the conflicts with her sisters, and she is not very motivated to take the necessary steps for her professional training (eighth joint action). In the last ninth joint action, the psychiatrist tries to convince her to undergo psychotherapy.

11.2.9 The Video Self-Confrontation Interview

After viewing the **first section,** the young woman thinks it is stupid because her voice sounds "so idiotic". Moreover, "…the images of what I had done came up in me again". Regarding the **second section,** the patient adds that her mother thought she could move out of the apartment if she passed the exam, which did not go down well with the young woman "so she really wanted to kick me out". She also expresses the thought that she did not say in the interview, "It occurred to me that people always said that my family was not normal. They used to say that I was still the only one who was normal. That's what my girlfriend said. My current boyfriend said this too. People also said that we weren't normal because my parents had separate bedrooms for… 16 or 17 years (have)… They also wanted to divorce at that time. But this did not happen because my little sister was very fond of both mother and father. But now nothing holds them back then… The father doesn't want me to leave because of this either. Because I am still holding the whole family together. He is afraid that if I leave, she (the mother) might leave too". When the research assistant mentioned that what she said was close to the young woman's heart, she said, "It was closer than I expected. I just didn't think it would take me like that because I was actually fine today". In the **third section,** the research assistant wants to clarify the patient's negative feelings, whether it would be shame or fear. She affirms the feelings of fear and says that they are much weaker today because she no longer feels watched. She was able to work this out for herself: "I once went into town one lunchtime because I wasn't eating lunch. Then when I was in town, I was like driven by something. I went to buy a piece of clothing by myself. I never thought I could do that. Now shopping in the city is not a problem for me. Maybe it's also imagination that people are looking at me. It is probably not like that in reality". The patient adds some more information about her self-harm. She says she once cut herself with scissors when she was about 6 or 7 years old. But, "About two years ago it really started. Every time I was home alone and feeling down, I would cut myself. It also happened whenever the older sister was visiting at home". The

young woman then adds further information about her sisters, their drug careers, and describes her relationship with them.

In the **fourth section,** the research assistant takes up the psychiatrist's question about the young woman's heavy breathing. For the past year she has had this "…about three times a month for one day". In the beginning, she only had it for a day or two. "But now it's coming on longer and longer". She also laments how hard it is for her to talk about her feelings, "I can't really express my feelings either because I've never been able to talk about it properly. I've also always been told to talk to people, and not to just eat it all up all the time. You just can't talk about feelings. You just can't."

In the **fifth section,** the young woman recalls something that didn't occur to her in the interview: "It occurs to me now why I hate my father so much. It's because of this very thing. My mother always spoke badly of him. That's why I hated him all the time. She always told me that she hated him. That's probably why everything went the way it did". She also mentions something from her childhood that she kept quiet about in the interview, "My mother used to hit us on the back with a cable very violently. But I could always forgive her because I loved her very much. I was never angry with her". The mother used to hit her "…probably because of the argument she had with the father. When I speak to her about it today, she replies that she is sorry, but that somehow she had to relieve the anger she had towards the father". When asked about her relationship with her mother, the young woman continues, "…Every time I came home from school, I wanted to tell her about what happened that day. But she could never listen. Even today, when I want to tell her something, she is just never home. She just never had the time. I know that I always feel like I need my mom. But I also know that I need to be independent on the other side. But still, I need someone to talk to". She complains not only that her mother has no time for her, but that she also pressures her to lie: "She is also still married to her father and has a boyfriend on the side. So she also wants me to lie to the father. She always wants me to tell him that she has gone out with a friend".

However, the young woman does not want to talk to her father: "When I was a child, he was never at home. So now I think I don't need him anymore. When I was a child, I would have needed him. That time has just passed." She offers one more addition to the interview regarding her father "…(he) might want to be a father to me again. He also got me the apprentice job. I worked at the same place as he does. But I don't really need him for that. I don't want him to do anything for me at all".

In the **sixth section** the young woman classifies her suicide attempt according to her understanding

> "The fact that I did that and now ended up here proved to me that I can still accomplish something and not fail at everything. I just sent out a cry for help in this way. I wanted to get back to the other side. I wanted to make sense of my life again. And by ending up here (at the psychiatric hospital) I think I'm back on the road to recovery."

In the **seventh section,** at the request of the research assistant, the patient offers more information about how it hurt her when her supervisor instructed her to do the task again when he was not satisfied, how she felt unfairly treated, how he praised her less than the others even though she could also do something he could not, like send a fax, and how she did not get any encouragement from her friend after the failed exams.

In the **eighth section,** the patient comments on her fears and how they restrict her actions: "That may be so (that I stand in my own way). But I just don't know how to overcome it. One is simply already afraid when one is given a new task to carry it out".

In the **ninth section,** the research assistant inquires about the details of the young woman's fears about going out alone. She said that she was always able to solve the problem somehow: "I also had a good friend at that time. I could always tell her if I needed her to bring me something from town… It's just more like sticking with the other students who might be able to help me get something done… It's just the people who then each get something done for me." She felt that it was because she "…just didn't (have) enough self-esteem. I just couldn't say on my own that I wanted this or that now. This made the girlfriend angry. That's also the reason why I had arguments with her". In this section, the young woman also mentions that she spoke her mother tongue at home, i.e. a foreign language, and therefore had problems with German pronunciation, for which she was ridiculed at school.

In the **tenth section,** the research assistant inquires about the details of the suicidal actions and the young woman recounts her attempt to drown, cutting herself and eventually eating broken glass, how she then spoke to her supervisor and then went to see her friend. She continues to recount the crisis she experienced when she was in hospital and her mother told her that her sister was back in the flat. Here the patient was overwhelmed by the feeling, "I have no home".

In the **eleventh section,** the young woman tried to dispel the impression that she does not care enough about her future, that is, a follow up job, which she needs to continue school. She thinks that she has not yet had time for this, as she was in hospital directly after the suicide attempt.

▶ **Summary**

1. In the self-confrontation interview, the young woman supplements her information about the interview, expresses new insights and describes feelings and thoughts that she had during the interview but did not express there.
2. In the first section, she again formulates her negative view towards herself and shares how she relived everything through narration. In the second section, she talks about her fear that her mother wants her to move out of their shared home. She then talks more about the development in the family and her parents' relationship with each other. She thinks she is keeping the whole family together. In the third section, the patient talks about her fears and how she overcame them when she decided to go shopping in the city alone. In the fourth section, the patient talks more about her breathing problems and links this to her inability to

talk about feelings. In the fifth section she adds to what she said about her feelings towards her parents. She thinks she hates her father because her mother told her a lot about her own hatred for the man. Moreover, her mother painfully hit her on the back with an electric cord. She remembers that her mother did not take the time to listen to her, which hurt her very much.

3. In the sixth section, the patient shares her view of her suicide. She considers it a success because she came to the psychiatric ward and can expect to get better. She wants to see meaning in her life again. In the seventh section she tells of how it offends her when the supervisor is dissatisfied with her performance. In the eighth section, she reveals that she is helpless in the face of her fears and does not know how to change that. She talks about how she maintained her acquaintances and friendships in such a way that others did for her what she felt she could not do for herself. In the tenth section, she shares her fear that she has no home because her sisters are moving back into their parents' apartment.

Case 10

12

12.1 Suicide Story: Ms. Aebi: When the Soul Cries Out for Help

Kornelia Helfmann

When he turns and walks out of her room, she knows: this time it's definite. He's broken up with her; he's completely emotionless, indifferent, cold. They'll never get back together. The last year has been a constant back and forth in their relationship; he's told her several times he doesn't want her anymore, but then he's always shown up and messed with her, played with her feelings. He would got to bed with her, then say it was all over the next morning, then he'd call her again after all, compliment her, and she would go soft again. She kept falling for him. He has a very charming way about him; he knows exactly what to do to get her. He never had to do much for it though: she wanted him, only him. The fact that they kept sleeping together, even though everything was supposedly over, that had always been a sign of hope for her. He always gave her that hope, but now it's finally over. He knows perfectly well that she will go crazy, that the world will collapse for her if he leaves her. So why does he do this to her; why is he so cold; why does he trample on her feelings so much? How is she supposed to live now, without him?

The big house is empty; she is alone. Her parents have gone out, to a restaurant; they are never there when she needs them. Outside, it's getting dark. She hears the front door slam downstairs, hears his footsteps on the gravel path as he walks through the garden into the street. He walks fast, then starts the engine of his car and drives away with squealing tires.

She's starting to scream. No, no, no. Tugging at her hair, pacing around her room like she's gone insane. No, no, no. Tears stream down her face, and she can't stop screaming, over and over. No, no, no.

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She had confided in him tonight that his best friend had tried to rape her. That had taken a lot out of her. He knew she had almost been raped as a child, and again later when she was 15. But his best friend Luke she trusted, and never had she thought he could betray her trust like that. It wasn't the first time he'd tried, by the way. She should never have gotten in the car with him and let him take her home after that party at her boyfriend's house when he hadn't wanted to drive because he's drunk too much. She'd had a few too many drinks too and there was no tram running anymore, so she was glad Luke offered. She should have said no, though. It was her fault he got so pushy: that's just how men are, when an opportunity presents itself they grab it. The second time it was her fault too. She had been alone with this Luke guy in his apartment, and then another friend of his had come over. They had probably poured some kind of drugs into her coke, and when she was almost passed out Luke held her down and his friend started undressing her. It wasn't until she started crying hard that they had stopped. It really could have ended badly for her. Also, why was she so stupid as to trust him when he had tried before? And today she told all this to her boyfriend. She had expected him to tell Luke off, but instead he just asked her why she was telling him all this and said that she shouldn't contact him anymore. This, when he should have been telling off his best friend and not her. She has always thought he was different from the men she has met so far. Yet he betrayed her trust, too.

The pain in her soul is unbearable. She bangs her head against the wall several times, and it doesn't hurt at all; the pain in her soul is stronger, and she keeps screaming. No, no, no. She almost can't stand the screams, but she just can't stop.

Above her desk hang photos of her. Her favorite photo was taken by her mother when she first started modeling, 3 years ago now. Shortly before, she had been with her mother in the biggest and chicest fashion store in town, where all the well-heeled women shopped, and the boss asked her if she would be interested in showing off the latest collection, at a fashion show. She, of all people. She was enormously flattered and immediately said yes, her mother didn't mind either. And after that, she was used as a model again and again. That's how she met her boyfriend. He sat in the audience with his mother, and she immediately noticed that he didn't take his eyes off her as she walked down the runway, showing off one dress after another. That night she tried even harder than usual. Again and again their eyes met. He was waiting for her by the entrance when the fashion show was done. He said he was fascinated by her, she was very beautiful, with a great figure, and then those dark eyes and beautiful long blonde hair. He invited her to a bar, and she was always going to say yes. They had barely been able to talk; the music was way too loud for that, but he had literally eaten her up with his eyes, and they met almost every night after that. He liked not only that she was good-looking, but also that she was articulate, had a sense of humor, that she was also feisty and sometimes provocative. Before they made love for the first time, she told him about the two near rapes, even though she was terribly ashamed of them. But she had wanted him to know that it might not be easy for her to have sex with him after what she had experienced. Maybe that was why he was so considerate then. She was grateful to him for that, and that's why she can't understand now why he didn't take

his best friend's brutal assault seriously. He'd made her feel guilty again, humiliated her. Just pushed her away. And she had thought she could talk to him about anything.

She tears the photo and stomps on it. Then she climbs onto her desk, rips all the photos off the wall and throws them on the floor. Now she can finally stop screaming, and she has no more tears either. Her eyes fall on the box of painkillers lying on the table next to her. She has been taking the tablets for a few days because she has problems with her wisdom teeth. And if they help with a toothache, maybe they'll help with the pain raging in her soul. A pain so fierce that it makes her feel desperate, powerless and half-ready to faint. She detaches some pills from the foil and swallows them, then throws herself on the floor and cries. She needs to swallow more pills, but her mouth is too dry. She runs out of her room, hearing her own breathing in the quiet house, her ears ringing, and almost falls in, the pitch black house. It's hauntingly dark. Her parents won't be back for a long time. When they go out, and they go out a lot, they always come home very late. The man she calls father, the man her mother is married to, likes to party. He's not her real father. When she was a kid, he used to hit her a lot, once so hard that she had a laceration on her forehead that should have been stitched up, but he didn't want her to go to the hospital. I guess he was afraid she'd say what happened, the coward. And her mother let it happen, terrified that he would leave her; she'd had a man run out on her before. But when he isn't there, her stepfather, when they are alone, she is the dearest mother she can imagine. If only she were here now! Why isn't she there? Why does she leave her so alone when she's in such a bad way?

She gropes for the light switch, the sudden glare blinding her and making her stagger a little. She climbs the stairs to the bathroom. In the mirror she sees her face, puffy, red-eyed, with snot running from her nose. She is disgusted with herself. She opens the medicine cabinet. She puts aside the strong pills she took after her abortion last year; she won't take them. Yes, she had been pregnant by this man who today threw her away like a piece of dirt, who used her body, forgetting that she also had a soul that he stomped on like an annoying insect. She didn't tell him about the pregnancy then, she had wanted to go easy on him; he was in the middle of his final exams and she didn't want to burden him with it, stupid as she was, always thinking of others and not herself.

She clears out the whole medicine cabinet and starts swallowing everything she finds. One tablet after another. In between, she drinks water from her tooth cup. She is terribly hot. She takes off her blouse, sees the scars on her wrist. Four months ago she cut herself. So much came together. She had stress with her boyfriend, the constant back and forth. She had stress at school; her grades were getting worse, she didn't know what to make of herself, what career to pursue. Her boyfriend was abroad at the time; she missed him a lot. She had no appetite, was losing more and more weight; it was clearly anorexia, she would have loved to starve herself out of the world. Everything was just negative: she had no hope left, for anything. So she started shopping with her mother's credit card. Buying clothes, handbags, shoes, jewelry… Until her mother found out. She had known it would be discovered soon, but somehow she had to distract herself from her problems, her frustration. Her mother was so disappointed; never in her life would she have believed this of her, her mother had told her, and she was disappointed in herself too. She was ashamed

of herself. That's when she cut herself in her room with a sharp kitchen knife: deep, deeper and deeper, until the blood splattered, the whole sink full of it. She felt no pain, not for a second; the pain in her soul was stronger. She felt no fear either, only a deep despair. Her mother suddenly came into the room and took her to the emergency at the university hospital, where they kept her waiting for half an hour with the open, bleeding wound, and when it finally came to her, the doctor asked if he should help her or if she would rather jump right out the window. That really shook her up. She then went to a clinic and got involved in therapy, but when the psychiatrist went on vacation for an extended period of time, she dropped out. She was very ashamed of the cutting because she realized what she had almost done to her mother. She is the only person who really loves her.

Then she was back with her boyfriend for a few weeks until he dumped her again. And she did everything possible to win him back. She knows she's good-looking: she has a nice face and a nice body. Or should she say had? Because after the anorexia came the bulimia. She tried to hide it, but when she was down to 40 kilos it became difficult. Her boyfriend said he wouldn't go to bed with a skeleton, and she tried to put on weight, but she was powerless against food and vomiting, she just had to do it to feel better at least for a short time.

By now she must have swallowed 40 tablets, maybe more, and the raging in her soul still hasn't calmed down. She feels no effect at all; she doesn't even feel sick, and so she takes the next pack, takes the tablets out of the foil and continues to swallow one after the other. It's like an addiction. At some point the pain, the despair, has to subside; she sits down on the edge of the bathtub and continues to swallow pills, drink water, swallow pills. By now, more than an hour has passed; it's raining outside. When she gets up and looks in the mirror, she notices the foam around her mouth. She tries to imagine what she will look like lying in a coffin, but she only sees herself in a bed in the hospital. In the hallway downstairs the phone rings; she hears it as if through cotton wool, like it's ringing in the middle of nowhere, and she feels like she's had too much alcohol. The last packet of tablets falls out of her hand.

12.2 Suicide Analysis: A Young Woman: I Was Like in a Trance

Ladislav Valach

> He said he would not contact me again… I started screaming… I saw pills on the table and started taking them …I was like in a trance

"How did it come to this? I was in a very great despair, in a powerlessness, in a helplessness, in a sadness and in a loneliness.".[1] In addition to these feelings immediately before

[1] *Notes*: The reader may bear in mind that the conversations with the patients were conducted in the local idiom, a Swiss dialect, and were transcribed by a student typist into written German directly during the transcription. This is therefore not a translation with literary pretensions. In addition, some patients are not native speakers of German.

her suicide attempt, the young woman describes how her boyfriend broke off the relationship. Immediately afterwards she describes how she had already been in a state of breaking up for a year with the boyfriend; how she deliberately cut her arm a few months ago; how she suffered from eating disorders and shopping addiction; abused her mother's credit card; had stress at school and did not know what to do in her life professionally. She also had already experienced several rape attempts in her life that she had to deal with. So, there are many medium-term and long-term processes that she counts as a part of her crisis situation and in which she wants to solve the problem situations with different concerns.

12.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

12.2.1.1 Medium-Term ('Projects') and Long-Term Concerns

It is certainly the "relationship with her boyfriend" to which the young woman attributes a decisive role in the crisis. It is above all the last year in which, despite his breaking off the relationship, they kept getting together and became intimate ("separation process", or "resumption"). She also reports on her "relationship with her body," which has been bothering her for a long time. She experienced her body as valuable to others because several times in her life people had tried to take her body by force with sexual intent and to take away her control over it. This long-term process, then, includes her experiences of "attempted rape" when she was six, 15, 16, and more recently. The long-term relationship with her own body also includes the period of 'self-harm' and 'eating disorder'. It is also in this context that a major concern of the patient is her "search for trust". Her trust was abused; she trusted her boyfriend very much and when he betrayed her trust, this plunged her into crisis. We also learn of her "relationship with her mother," which was so important to her that she cut her forearm when her mother found out that the young woman had betrayed her trust and used her credit card to make excessive purchases. Among all these experiences and concerns is the patient's "eating disorder." She reports anorexia and bulimia. Last but not least, she mentions her school, where she has been experiencing a lot of stress lately and has not been able to realize her desire to succeed in school ("school success"), as well as her insecurity in her "career choice." Above all these concerns is the question of "life and death". The patient has also been preoccupied with the issue of "dying" for some time, as she has already been treated twice in the emergency ward for a suicide attempt.

12.2.1.2 Long-Term Concerns

The question arises as to what long-term concerns of the young woman were so violated by the termination and dissolution of the love relationship. The patient mentions in the first sentence "despair, powerlessness, helplessness, sadness and being alone". Such concerns, experiencing the world and our situation as something we can influence, feeling supported by others, and knowing problem-solving is within reach is common to all people. However, when one experiences situations as a child in which these concerns were thwarted, this

leaves a lasting impression on the person. This is the case with child and adolescent sexual abuse and rape. Additionally, if children and young people experience massive abuse of trust, this is then reflected in the intense desire for "trusting relationships." The patient also recounts her concern to "reintegrate her body adequately into her life." She experienced how her body was confronted with violence. Moreover, it is quite conceivable that the young woman detached herself mentally and emotionally from her body during such moments of threat. Her preoccupation with her body can be seen in her "eating disorder", her effort to regain her boyfriend through "bodily devotion" even though he broke off the relationship, and finally in her "cutting on her forearm" after "disappointing her mother". Complementing this understanding is the fact that the young woman occasionally "worked as a model" and thus foregrounded her body, her outer appearance. She also formulates these concerns herself as an "effort to have her body and soul understood and appreciated together." Of her boyfriend she says in this regard "But, because he was so fascinated by my body, he forgot that I also had a soul. My soul always came up short." When asked by the doctor "That's when the trust you gave him was abused?" she replied "Yes. Abused like my body and my soul. That then led me to this" (that she tried to commit suicide).

She then understood her "relationship problems" as "soul pain", which she then tried to attend to in her own way "I was just far too busy with my soul pain. I just wanted to get over that somehow. So I just kept buying and consuming.". When she finally cut open her forearm, she said it didn't hurt her because "when you have pain in two places, you only feel one of them. In my case, the mental pain was stronger". Before her second suicide attempt, when she threw a glass at the wall, threw herself to the floor and screamed, she described her feelings as follows: "But at that moment, you're just enveloped like you're in a hole. You just can't climb out at all. You can't, even if you want to. You scream in those moments. But the soul always screams much louder. This drowns out the physical screaming." Her effort to unify body and soul is also evident from the doctors' characterization of her treatment after her suicide attempt "You just feel like an object, not a person. And this person is bad enough already. You already feel like a commodity yourself. Such things never affect the body, such things only ever affect the soul."

12.2.1.3 Medium-Term Concerns "Projects"

In her conversation with the psychiatrist, the young woman makes it clear that her suicidal action was embedded in some medium-term concerns, which in turn stem from a longer life context. Her effort to combat her soul pain through a medication overdose is integrated into a process of "harming herself", perhaps also a "wanting to die", since a few months ago she cut her forearm so badly that she had to be treated as an emergency case in hospital. This in turn was part of the "breaking up with her boyfriend" process. Her boyfriend called off the relationship, but kept checking in or returning the young woman's calls, and she then continued their intimacy, although he always refused her relationship requests. It was during this time, also in the context of these arguments and failed requests that her "eating disorders" occurred. First "anorexia" with all its complex goals and motives, and subsequently "bulimia". Comparable to these destructive concerns was also the patient's

"shopping addiction". The "attempted rape" by an acquaintance of her boyfriend and the disappointment, which the patient experienced as an "abuse of trust," when her boyfriend did not pay attention to this episode, also belong to this time.

▶ **Summary**

1. The patient described her "relationship with the boyfriend" and especially the prolonged "separation process" as crucial long- and medium-term concerns for her medication overdose.
2. She experienced "rape attempts", the consequences of which she had to struggle with for a long time. Her "relationship to her own body", "self-injuries" and "eating disorders" were shaped by this.
3. Her search for a "trusting relationship" and efforts to "adequately integrate her body into life" are also to be seen as important long-term concerns in this light.

12.2.2 Actions in the Suicide Project

Joint Actions: Project: Dissolve Relationship; Patient (P), Friend (F), Friend's Acquaintance (B)

Emotion P: I was in a very great despair, in a helplessness, in a powerlessness, in a sadness and in a loneliness.
Cognition P: It came about because my ex-boyfriend was with me.
Cognition P: It was always back and forth between the two of us.
Cognition P (action F): He juggled my feelings relatively strongly.
Action F: He was then at my house.
Cognition F: But then it suddenly became clear to him that he no longer wanted anything from me. And all that after 1 year.
Action F: He then slept at my place again.
Action F: The next morning he said again that he didn't want anything from me after all. That happened about six times.
Cognition P: I kept falling for him in my blindness. He has a very charming way.
Cognition F: He knows how to persuade me.
Cognition P: That's what got me to the point where I ended up here.
Action F: He told me this 2 weeks after we had last intercourse together.
Cognition P (Emotion P): At that moment, a world simply collapsed for me.
Emotion F-: (He said it) With indifference.
Action F: He just said it so he would have said it.
Cognition F: But what was going on inside me, he didn't care.
Action F: He told me that he didn't want me anymore. It had all become clear to him now. He knows that he doesn't want me now. He just says everything in this way.
Emotion P: That was very bad for me.

Cognition P: I still had hope that we would get back together because we were still getting along, even during the time we were no longer in a relationship.
Joint Action P, F: We still slept together without having a relationship.
Cognition P: Of course, I always had the hope that everything would come out okay.
Action F: He always gave me these hopes, too. It wasn't that he just drew a line and said that he didn't want to anymore.

Joint Actions, Attempted Rape; Patient (P), Boyfriend (F), Acquaintance of Boyfriend (B)

Cognition P: I am so attached to this person because I have experienced three near rapes in my life. That was when I was six, when I was 15, and when I was 16.
Cognition P: I just felt like he wasn't going to do that. From that point of view, of course, this was a very big abuse of trust.
Action B: It almost happened 2 months ago for the last time. This time it had been his best friend.
Action P: I had told him (ex-boyfriend) that.
Action F: Then he asked me why I was telling him this.
Feeling P: In such moments it is very humiliating for a woman. You just make yourself feel guilty.
Cognition P: I am to blame for this… I should not have done this… Yet there is nothing at all to blame me for. And not for all three times.
Action P: I told him 1 day later. The one at six and the one at 15 he knew. The one at 15 he found out from someone else. The one at six I told him myself.
Action P (Cognition P): I told him this because I felt that I might have trouble sleeping with him after these experiences.
Cognition P: There (sexuality) was everything normal. Just the way it should be in a relationship. That is also the reason why I trusted him so much.
Action F: And then suddenly he comes and says I shouldn't tell this story to him….
Feeling P: Yes (the trust I have given him has been abused). Been abused like my body and soul. That then led me to this.
Action P: I told him that 4 weeks later when we almost slept together. He spent the night at my place.
Joint Action P, F: Two weeks later we talked about it once.
Action F: And that's when he told me to my face that he didn't want to anymore.
Cognition P: It was simply an abuse of trust.
Action F: … and then he pushes me away.
Action F: He then left. He said that it would be better if I did not contact him now. He would not get in touch again either.

Second Suicide Action; Patient (P), Father (V)

Cognition P: At that point, it was just definitive for me.
Action P: At this point, I was starting to freak out.

Cognition P: I was alone in this big house. We have a house. It was dark outside. I was all alone in this house.
Action P: I started screaming around.
Cognition P: Since I also had problems with my wisdom teeth at the same time, there were some pain pills lying around on the table I was sitting on.
Action P: I looked at these and immediately took them. I then took seven or eight strong painkillers. That's when it started. I then cleared out the whole cupboard. In total I took about 80 tablets.
Feeling P: I was actually still doing well at that point.
Action P: I was walking around the house. I was on a "high." I was like in a trance.
Action V: Then my father came home. He found me crying. He told me to talk to him if I had a problem.
Action P: In the meantime, I kept taking pills. It was like an addiction. I just kept swallowing another pill and another.
Action V: Then when he realized what I had done, he took me to the hospital. Straight to the emergency ward.
Cognition P: These things are spontaneous. You don't plan those things in advance. No.

First Suicidal Action; Patient (P), Mother (M)
Action P: … I've done it before. I cut myself 4 months ago.
Cognition P: On the whole (did it have to do with my friend) yes.
Action P: I took my mother's bank card three times and used it. I was in a "buying frustration" state at the time.
Cognition P: He (ex-boyfriend) was away overseas for half a year at the time.
Action M: She (mother) then found out.
Emotion P: I felt sad for myself because I'm not a person who does that kind of thing otherwise.
Action P: After that, I went to therapy.
Action P: I was in a clinic for a week. I then broke off my therapy. My therapist had gone on vacation for 2 weeks. We then just lost track of each other.
Pain P-: (Cut on arm). But I didn't feel it at that moment. When you have pain in two places, you only feel one of them. For me, the mental pain was stronger.
Pain P-: I didn't realize.
Cognition P: I did know what I was doing. So I acted consciously.
Pain P-: But I didn't feel it. It didn't even hurt.
Cognition P: The moment the blood started spurting out of my arm, I became truly aware of what I had done.
Emotion P: But I wasn't afraid at that moment. No. At that moment the despair was all the more in me.
Action M: I was surprised by my mother, who had knocked on my room door and wanted to enter.
Joint Action P, M: Then we went to the emergency doctor together.

Cognition P: It (blood) dripped into the sink.
Action P: I was just in my room cutting my arm wider and deeper. I didn't hear anything the whole time. If no one had come, I would have kept cutting my arm futher. I didn't notice it.
Pain P: I just didn't feel anything. The pain of the soul was simply the predominant component.
Cognition P: And I think that you really can only do this to yourself with a great mental pain. The inner equilibrium was simply no longer in balance.
Cognition P: That wasn't my boyfriend anymore. He left me a few months ago. At that time there was just a constant back and forth between us.
Cognition P: I was just in a buying funk at that moment.
Cognition P: Buying frustration is a reaction.
Emotion P: Well, I've already enjoyed what I've bought.
Cognition P: It wasn't like I just bought something and then just put the shopping bag in a corner. I was already wearing those clothes and using the other items.
Cognition P: (I did it) Just to distract myself. Just distraction.
Emotion M: She (mother) was just disappointed in me.
Cognition M: She would never have expected this from me.
Cognition P: And I never thought this of myself either. I didn't even realize what I was doing. I was just way too busy with my soul pain. I just wanted to get over that somehow.
Actions P: So I just kept buying and consuming. I just wanted to distract myself as much as possible, just switch off. I wanted to get away from all my problems.

Second Suicide Action; Patient (P), Boyfriend (F)
Cognition P: Now it's almost 5 months.
Action F: So he put an end to it then (a year ago).
Action P: I react very late. I react very late to such pain. I went home as if I had been on drugs.
Cognition P: I didn't realize it. Only later did I understand what had actually happened.
Action P: I then just tried everything to get him back.
Joint Action P, F: This then led to us going to bed together a lot.
Action F: Yes. That was in the fall (he/ex-boyfriend has returned).
Cognition P: Yes. It was just definitely off now.
Cognition F: But he had actually known this definite for a long time. But I was always a very beautiful woman for him. It also appealed to him that I worked as a model. Body, … He felt that I could get anybody. But because he was so fascinated by my body, he forgot that I also had a soul.
Cognition P: My soul always got the short end of the stick. And a person simply doesn't consist only of the body.
Cognition P: I think you can never generalize suicide attempts. Some people go to the pharmacy to get medication. These plan everything in advance. With me, it was simply a short-circuit action.

Cognition P: I just knew I was going to go insane when he said it was all over. I knew I couldn't take it.
Action P: I also told him not to say it.
Cognition F: But he was going to say it.
Cognition P: I knew I couldn't take this, but I never expected such a reaction from myself. This box of painkillers was just lying right next to me. I don't know what would have happened if this had not been next to me. I don't know how far I would have gone.
Cognition P: In those moments, you're just alone. Or if you're not alone, then at least you feel alone.
Cognition P: But at that moment you're just enveloped like in a hole. You just can't climb out at all. You can't even if you want to. You scream in those moments. But the soul always screams much louder. It drowns out the physical screaming.
Action P: I threw the glass against the wall.
Action P: (I screamed) Just "NO."
Action P: Really freaked out… No. I just screamed, I was….
Action P: I was jumping around in my room, I was lying on the floor, I was crying… I don't know either. Nothing of consequence, really. I just threw the glass against the wall and then I just cried.
Emotion P: Then I just had the feeling that now I just couldn't take it anymore. I could no longer bear my own crying, although I could no longer stop crying. There came a time when I couldn't cry anymore, because nothing was going on. But somehow you have to release your emotions.

First Suicidal Action; Patient (P)
Emotion P: I was ashamed of myself at that moment that I am capable of doing something like that, that I am capable of doing something like that to a person who likes me so much.
Cognition P: I was completely out of it then, too.
Action P: I just kept cutting at my arm. One cut after the other, one deeper than the other.
Emotion P: The more the blood flowed, the more joy I felt.
Cognition P: You can't generalize a suicide attempt. Every person feels this differently again. The only thing we all have in common is that we were desperate.

Second Suicide Action; Patient (P)
Action P: When I stood in front of the medicine cabinet, I always checked what I was swallowing.
Cognition, Action P: I just looked up what I was eating. I saw myself in the hospital, but not in a grave. Therefore, it was simply a cry for help.
Cognition P: I just knew that certain painkillers were very strong.

Cognition P: I didn't find those tablets. But whether I wouldn't have taken them if I had found them, you can't say. Because the emotions are just very strong.
Cognition P: You are never completely out of it (I was still thinking about what I was ingesting at that moment).
Cognition P: But in such moments there is simply no mind left. Even if you know that life goes on, at such a moment you no longer think about it. One has simply lost hope. You think of so many things that could hold you back.
Action P: As I walked to the medicine cabinet, I thought about what my life looked like.
Cognition P: I have stress at school. I don't know what I want to be when I grow up. Just everything has turned negative. That gave me the impetus to commit this crime. In such a moment one is always looking for reasons to support the action. You excuse yourself in this moment.
Cognition P: When you're in a hole, you just drag everything down even more.

After the Second Suicide Attempt; Patient (P), Boyfriend (F), Father (V)
Action F: But now a new year has dawned and with it he draws a line under the events of the past year.
Action P: I spoke to him on the phone today.
Cognition F: He knew I was in intensive care.
Action V: But my father told him not to contact me again.
Cognition V: Because he had a shock when he saw me. And that with his profession as a hospital employee.
Action P: I told him not to feel guilty about me being there now in the ICU.
Action F: But he just replied to me that he had to go on eating now.

Pregnancy; Patient (P), Boyfriend (F)
Cognition P: And I was still pregnant by this human.
Cognition P: That was a year ago.
Action P: I hadn't told him. He was in his final exams and that's why I thought….
Emotion P: I have feelings of hatred. I don't know. But when you survive moments like that, you grow from it. You become strong from it.

After the Second Suicide Attempt; Patient (P)
Cognition P: In the ICU, I told myself that love can never take you that far. I always took it all on myself with the rapes, almost-rapes that is. I just always took it all on myself.
Cognition P: If a person likes you, whatever situation you're in, and they know you're in a really bad place, they'll come as fast as they can. That's a very normal humane reaction.
Cognition P: I knew he was sitting in a club playing cards at the time.
Cognition P: You know it (drug overdose) is not worth it. These experiences make a person strong. I don't want to say that if someone attempts suicide and doesn't succeed that they are strong. It just made me strong as a person. It's not that if I did it again that I

would be strong about it again. No. But this time it made me strong. I can now just say NO to its face. Maybe this is what it needed.

Cognition P: It just changed something. Even at the latest when you're in intensive care, you have to think about it. That's already the case because you simply have to fight for yourself.

Cognition P: In a way, it helped too. I just realized that I was indifferent to this person. I then just asked myself about the point of the whole relationship. Is it worth me sacrificing myself for a person in this way? That made me strong. I will never go that far for a man again. I will also never take on guilt again for any reason. Everything he did to me … that he just slept with me, and then the next morning he told me it was all over now. And then I called him again a week later and told him not to feel guilty. You just take it all in. Even when his best friend almost raped me….

After the Rape Attempt; Patient (P), Boyfriend (F)

Action P: The next morning I called on the spot for sexually harassed and raped women.

Action A: These asked me if I had any evidence.

Action P: I told them I had no proof.

Action A: That's when they told me to see a psychologist in town about this case.

Emotion P: In that moment, you have so many guilty feelings. You just feel so humiliated as a woman in that moment.

Cognition P: Only once you've been to the very bottom of this hole do you know what it looks like at the top.

Cognition P: There's nowhere to go but up. If you're already at the bottom of the hole, then you can only go up. You can't go any lower.

Cognition P: It certainly took it. A lot of things have come together. It's anorexia, it's bulimia, … I've gone through so much process in this last year. And now all these issues are finally coming up. I have always repressed all of this and never talked about it. It was just taboo for me. This is the first time I've told anyone here about my best friend.

Cognition P: If you don't always repress something, then it can never get that far. If you always talk about something… Only pent up emotions bring a person to such an action. I would never have done this either if my best friend had been by my side. I was just alone.

Experiences with Physicians After Suicide Attempts; Patient (P), Physician (A)

Action P (Action Doctors): What I can tell them is that the way the doctors acted towards me in the hospital, that's absolutely terrible. Just terrible.

After the first suicide attempt:

Doctor's Action: In the beginning, my doctor left me sitting in the emergency ward for half an hour with an open vein.

Cognition P: I also realize that other cases take priority, but right away so long….

Doctor's Action: when he saw me he asked me, "do you want me to help you or do you want to jump right out the window?"

Action P: Yeah. I just looked at him and told him you don't mess with stuff like that. And then what do you do with it? You feel guilty again. Especially for these people it is important that you are there for them. Such things are cries for help that clearly have to be taken seriously. I know how it is. I wasn't taken seriously.

Action P: I was then sent to a clinic.

After the second suicide attempt:

Cognition P: Last time a psychiatrist was present.

Cognition P: She was good, but still, I could have killed her.

Cognition P: They gave me coal, because I had had the tablets in me for far too long. They also didn't know exactly what I had taken.

Action P: So I took the coal. I then just vomited. On top of that I had six or seven infusions.

Doctor's Action: She then told me to talk to her now.

Action P: But I could only answer her that I was feeling so bad at the moment and that I only had to vomit all the time. Then I set off anyway. But on the way to her I had to vomit. Even during the conversation with her I vomited.

Action Doctor: Then she told me that I apparently have experience with vomiting.

Action P: But I then replied to her that I didn't.

Cognition P: But in fact, I already have bulimia.

Emotion P: That was good for me, because I used to deny everything. But the way… You just deal with it all with such a coolness. You just feel like an object, and not a person. And that person is in bad enough shape. He already feels himself a commodity. Such things never affect the body, such things always affect the soul.

Cognition P: Then a doctor just comes and says what we have, soberly and factually. But we figured that out a long time ago, too. You just have to be a little more delicate with the patients. I don't mean that the doctor has to hug the patient. But one should abolish this anonymity a bit. It's just so bad in this situation. Especially for someone who really wanted to kill themselves and didn't achieve their goal, that's humbling enough. To me, those were just cries for help.

Stay in the clinic for the current interview:

Emotion P: I'm so glad I came here. Because here they also took all this seriously. That's why I feel better.

Cognition P: I'm also around people here who have experienced similar things. And with these people you can talk about it. That also encouraged me to speak. ◄

► **Summary**

1. The patient first tells of her actions within the long and medium term concerns which are relationship dissolution.
2. She then describes actions of the present suicide attempt, the first suicide attempt, then she goes back to the last suicide attempt, then she tells about the first suicide attempt and comes back to the actions of the last suicide attempt.

3. The patient also recounts her actions and encounters with her father and ex-boyfriend after the current suicide attempt and then addresses the time of her pregnancy and abortion.
4. She comes back to the present where she describes the attempted rape by her ex-boyfriend's good friend.

12.2.3 Problems of Action Organization

Something happened in the young woman's order of goals so that the patient repeatedly put herself in a life-threatening condition and could even have died. How could this young woman, who reported a number of important goals that she was striving to achieve in order to give her life a better quality and that she had to live to achieve, want to end her life? She wanted to succeed in school, to live a loving and trusting partner relationship, to be respected, to be taken seriously, and to be perceived in her personal identity. She hoped to be admired, to be understood in her inner self, not to be alone, not to repress negative experiences, to live without guilt, and to be strong. She desired not to sacrifice herself for someone, to absolve herself of responsibility for the rape attempts for which she felt guilty. She wanted to choose a profession, to have hope, not be held back, to act with reason when in crisis, to get help, to distract herself from and get away from her problems by shopping and consuming, to overcome soul pain, not to disappoint her mother, to attain inner equilibrium, and much more – because behind every long and medium term concern, just as behind every action, there are goals, as stated above. It can seem complicated to keep all these goals in constructive order with each other. But whatever happens, the life-sustaining goals should not be disregarded. How can other goals be given top priority and the goal of life-sustaining actions be forgotten, or even replaced by destructive actions? We can observe this shift in the goal order and the action organization order at different points in the young woman's life. She was the victim of attempted rape and took responsibility for it by feeling guilty, probably in order to maintain the order of respect and trust in adult relationships. She engaged in a partner relationship that became her ultimate goal, to which she also subordinated her life. She wanted to receive help and, because she could not communicate this, she took actions that obviously violated rules and norms to indicate her distress. She self-described her suicide attempt as a cry for help. She exhibited disordered eating patterns and shopping addictions for which she stole her mother's credit card. She seriously cut her forearm and a few months later she overdosed on medication. The suicidal action itself also came about in a series of problematic breakdowns in the order of action. The patient recounts how all she could do at home was scream, throw a glass at the wall, cry until she couldn't anymore, and then take the medication overdose. Keeping in mind that she was only 6 years old when the first rape attempt was made, we can imagine the reactions of the little girl whose emotional and mental state the patient was in. This is connected both with her way of seeking help at that time, and with the subordination of life to other concerns.

▶ **Summary**

1. The patient reports a large number of goals and concerns tied to life. Nevertheless, the order of goals gets confused, so that she subordinates the highest one, "to live", to other concerns.
2. She suggests that her rape experiences made some goals, such as "living in a trusting relationship" more important to her than her life.
3. Her experience of existential threat stems from the time when she was not yet able to develop her communicative skills in this regard, so that even later, in crises that she experienced as existentially threatening, she sought help with the communication repertoire of that time with "making herself sick and showing herself". She suffered from eating disorders, self-harmed, took a medication overdose and spoke of her compulsive buying.
4. The ingestion of the medication overdose took place in a state of altered order of action, which was fed by the communication repertoire of the young child.

12.2.4 Consciously Prepared or Spontaneously Undertaken?

In the case of this young woman, the question of the problems of organizing action is closely linked to the question of whether her suicidal action was consciously prepared or came about spontaneously. While the listener is more than guessing at the outcome of the patient's crisis, it seemed unclear to the patient until she saw the pain medication on the table. However, the patient asserted that while the idea of overdosing did not occur to her until she saw the pills, she paid close attention to what she was taking because she saw herself "in the hospital, but not in the grave." Although she described her action as spontaneous and unplanned, we would nevertheless characterize it as a goal-directed action. Such an action is not characterized by pre-planning. In an action, we speak of "plan" to refer to the cognitive processes behind the action steps. When the patient saw the painkillers on the table, she brought out her suicide project, that is, a mid-term goal-directed process (triggered by a perception; a process called "bottom-up" steering "from the bottom up") and then carried out the suicidal action. Thus, her suicidal action was initiated "bottom-up"-"from the bottom up"-but directed "top-down," "from the top down." The intensity and activity of the patient's suicide project is evidenced by the fact that she had already been treated for a suicide attempt in the emergency department several months ago. In addition, her biography contains experiences with which she associates many personally relevant goals and which are associated with suicide and suicide attempts in suicide research. We can speak here of a suicide career.

▶ **Summary**

1. The patient describes her medication overdose as a short-circuit action probably due to the perception that her thinking, feeling and acting did not follow her current rules and habits.

2. Nevertheless, her suicidal action was a deliberate one, driven by a goal, even if the presence of the medication helped her to bring out her "suicide project."

12.2.5 Problems of the Action Monitoring Processes

How did the consciousness, attention, emotional system, and pain sensation, all action-monitoring processes, function during the patient's suicidal action? The young woman describes her sensation when she was in an acute crisis, throwing a glass against the wall, rolling on the floor, crying and screaming as follows: "But at that moment you are just enveloped like in a hole. You just can't climb out at all. You can't even if you want to." This observation can also be understood to mean that the young woman was aware of her actions but did not reflect them as actions that she could correct if necessary. She reported a complex situation when she perceived herself in this situation "I just knew I was going to go insane when he said it was all over. I knew I couldn't take it. I also told him not to say it. But he wanted to say it… I knew I could not bear this, but I never expected such a reaction from me." The young woman describes her state of consciousness at the moment of the suicidal action as follows "… (there were) some painkillers lying around on the table where I was just sitting. I looked at these and immediately grabbed them. I then took seven or eight strong painkillers. That's when it started. I then cleaned out the entire cabinet. In total, I took about 80 pills… I was on a "high." I was like in a trance." In the first suicidal action, when she cut herself, she was also "completely out of it." These are clearly problems of cognitive action monitoring. Suicide research shows that suicidal individuals are more likely to have this skill of "stepping away" than others.

Emotional monitoring is about developing adequate emotions and also feeling them. Conflicting emotional situations are often destructive if they cannot be resolved in the sense of higher goals. The young woman describes her emotional state as the crying of the soul "But in this moment you are just wrapped up like in a hole… You cry out in these moments. But the soul always screams much louder. This drowns out the physical screaming." "I just felt then that now I just couldn't take it anymore. I could no longer bear my own screaming, although I could no longer stop screaming. There also came a time when I couldn't cry anymore because nothing was going on. But somehow you have to release your emotions." The patient's feelings dictated a series of irrational actions, indicating that she was unable to consciously translate these feelings into adequate actions according to her hierarchy of goals, even when the immediate acting out of an intolerable feeling seems expedient. In the first suicidal action, the monitoring systems of the patient's consciousness and feelings also played a role in the construction of irrational actions, but these were no longer uncontrolled "acting out." She reported that her "cutting herself" was closely linked to "being abandoned by her boyfriend" "I cut myself four months ago. In the grand scheme of things (it was to do with my boyfriend)… I took the bank card from my mum (…) and used it. I was in a "buying frustration" state at the time. She (the mother) then found out. I felt sad for myself because I'm not a person who does that kind of thing

otherwise." The patient describes her emotional monitoring as not adequate in terms of the consequences of her action (cutting herself on the forearm) "…I wasn't scared at that moment. No. In that moment, the despair was even more inside me."

The young woman is very aware that her memories of her attempted rape and the feelings associated with it play a role in her current suicide attempts. The feeling of abuse of trust, which she experienced several times in the past and which mirrored a very threatening situation, keeps intruding in a situation which she interprets as a breach of trust and which thus becomes an existential threat: "I am so attached to this person because I have already experienced three near-rapes in my life. That was when I was six, when I was 15, and when I was 16… I just felt like he wasn't going to do that. From that standpoint, of course, this was a very big abuse of trust." But this is a perturbation or malfunction of the emotional monitoring system, which provides the person with an inadequate assessment of the current situation, because a breakup, while regrettable, is not an existential threat.

Pain perception, as a third monitoring system played a role in the patient's first suicide attempt when she cut her forearm "It didn't even hurt." This is evidence of a failure of a monitoring system.

The patient describes the faulty interaction of the monitoring systems when she suffered a life-threatening cut on her forearm. She says she did not feel it. This would indicate "not feeling the pain". But she feels that becoming aware comes from the interaction of multiple systems. "…I didn't feel it… I did know what I was doing. So I was acting consciously… But I didn't realize it… The moment the blood started spurting out of my arm, I became really aware of what I was doing." A perception is not tapped into proper conscious content with meaning until it is associated with adequate feelings. The young woman describes the interaction of feelings and pain, two other monitoring systems. She says "When you have pain in two places, you only feel one of them. For me, the mental pain (her feeling) was stronger (than the cut on my forearm)."

This means that faulty monitoring not only enables, fosters, and contributes to a suicidal action, but is significantly involved in its genesis and execution.

▶ **Summary**

1. The young woman describes problems in all three monitoring systems related to her suicide attempts: Consciousness, Emotion, and Pain Sensation.
2. The first time she tried to commit suicide, she was out like a light. On her second suicide attempt, she was as if in a trance.
3. We can best understand the problems of emotion monitoring from her confusion of emotion memories with the reflection of the present situation.
4. When the patient cut herself and felt no pain as she was suffering more from her mental pain, she describes her problems in pain monitoring.

12.2.6 Problems of Action Energization

The problems of emotional action monitoring are closely linked to the problems of action energization. The inadequate emotional mirroring leads to inadequate action energization. The young woman expresses this most clearly in her description of her actions immediately before taking the overdose "I threw the glass against the wall. (I shouted) Just 'NO'… Really freaked out…."

"I was jumping around my room, I was lying on the floor, I was crying…" Here irrational and destructive courses of action were energized. This was followed by the suicidal action step "…There were painkillers on the table… I looked at them and grabbed them straight away…" The young woman also describes expending energies to cope with her emotional states so that she interferes with her other monitoring systems "I didn't even realize what I was doing. I was just way too busy with my soul pain. I just kind of wanted to get over that. So I just kept buying and consuming. I just wanted to distract myself as much as possible, just switch off. I wanted to get away from all my problems."

▶ **Summary**

1. The patient relates how, just before her suicidal action, she energized irrational and destructive courses of action, such as jumping around the room and throwing a glass at the wall.
2. She spent her energies on overcoming the soul pain and carried out her suicidal action and other destructive actions subliminally and could not energize other life-saving action alternatives.

12.2.7 Suicide and Interactive and Joint Action

The suicide stories of this young woman show that she did not want to commit suicide out of a failed relationship to the world per se, but that concrete relationships with other people were decisive. These are, first of all, relationships with and encounters with persons who remained anonymous and who attempted to rape her. Subsequently, and very persistently, the patient suffered from the termination of the relationship by her partner. In addition, she was sexually harassed by a friend of her partner who attempted to rape her. When she then reported this to her partner, he took it with an indifference that she felt was a massive abuse of trust. Of her father, she reported that he advised her to speak to him if she had any problems. At this point, the patient was already in a state of "trance," which is also when she took the overdose. Only at the end of the session does the young woman reveal that the stepfather beat her brutally. The young woman mentions her relationship with her mother in a more complex action context. According to her, when her partner left her for the first time and went abroad, the patient suffered from a soul pain which she tried to cope with by distracting herself by going on a spending spree. To do this, she took her mother's credit card. Was she doing this to punish her mother for poorly protecting the child from rape

attempts? How important this relationship was to the patient is evident from her reaction. When it came out that the patient was abusing her mother's credit card, the young woman was disappointed in herself and cut her forearm until her mother found her in her room and took her to emergency treatment. Thus, the patient's relationships with other people around her could be considered the crucial processes in her suicide.

▶ **Summary**

1. This patient also describes her suicidal action from a relational context with other people.
2. They are mainly the broken relationship with her ex-boyfriend and his indifference to the patient's attempted rape by his acquaintance.
3. The rape attempts that the patient experienced in her childhood have a very lasting effect on her crisis management strategy.
4. The patient also links her relationships with her father and mother to her suicidal action. The stepfather beat her brutally and the relationship with the mother seemed insecure to the patient. On the one hand, the patient wanted to punish her by abusing her credit card and when the mother showed disappointment, the patient responded with self-harming actions.

12.2.8 The Young Woman's Conversation with a Psychiatrist

How does the young woman, together with the psychiatrist, shape the conversation, the telling of the story of her suicide attempts? In the **first joint action,** the psychiatrist asks the patient to describe how it came about that she took an overdose of tablets and thus offers the task of the joint action. The patient takes on this task ("How did it come about?") and also makes it her goal. She describes her emotional state at the time, how her boyfriend's termination of the relationship and her unsuccessful efforts to maintain it led to how a world came crashing down for her. They then work out in detail how the ex-boyfriend formulated his breaking off of the relationship, what feelings he radiated, what this triggered and meant in the patient. She justifies her deep dependence on him through her experiences of attempted rape in the past. The attempted rape by the friend of her ex-boyfriend and how the ex-boyfriend did not want to know about it played a special role. The young woman felt that this experience was a massive abuse and breach of trust.

In the **second joint action,** the psychiatrist wants to elaborate on the young woman's experiences immediately before the suicidal action ("…what was going on inside you up until the time you took the overdose of pills") after they discussed the suicide preconditions in the first joint action. She recounts how she began "freaking out" after the boyfriend left, overdosed, and was then taken to the emergency department by her father. When asked by the psychiatrist how one comes up with the idea of suicide, she reports that such actions are spontaneous and that she had done the same when she attempted her first suicide. At that time, when her boyfriend left her for the first time, she took refuge in

eating disorders and a spending spree with her mother's credit card. When her mother found out, the young woman cut her forearm. The patient then describes in detail how this suicide attempt occurred, all that she experienced, and how she felt. The psychiatrist asks some questions in order to understand the timeline and the connections between the internal and external events.

In the **third joint action,** they deal with some technical problems of recording.

The common task of the **fourth joint action** was to clarify the events and experiences in the period between the first termination of the relationship by the boyfriend almost 5 months ago, the first and the second suicide attempt by the patient.

The **fifth joint action** is devoted to the question of consciousness during a suicide attempt. The patient describes how, because of her mental pain, she did not feel the physical pain when cutting, how she felt as if she were in a hole from which she could not get out and how, during the second suicide action, she experienced herself as having "gone berserk", hating herself for it but unable to stop, and how she then took the painkilling tablets lying on the table without much thought.

In the **sixth joint action,** they explore the similarities between the two suicide attempts. The young woman said that in the first suicide attempt she was desperate out of shame and in the second out of rejection and abuse of trust, which was then decisive for her action.

How far the idea of the fatal outcome played a role in the overdose is the question which the psychiatrist wants to pursue in the **seventh joint action.** "I saw myself in a hospital, but not in a grave," said the young woman. Nevertheless, she qualified "But at such moments there is simply no mind left."

In the **eighth joint action,** the psychiatrist inquires about the relationship between the patient and her boyfriend. How it was already over at the time of the first suicide attempt and how they currently deal with each other. In the process, the young woman confides in the psychiatrist that she was pregnant by her boyfriend a year ago, but she did not tell him because he was taking his final exams.

With the question "How do you feel today when you think about him?" the psychiatrist introduces the **ninth joint action**, in which they turn to the patient's feelings and reflections on her relationship with her boyfriend. Here the young woman describes how she is slowly freeing herself from the guilt she felt at the attempted rapes, at the breakdown of the relationship, at her destructive confrontation with the feelings that arose from them. She feels this as a strengthening. It has also become clear to her that she needed to talk about her feelings and problems and that she was alone.

In the **tenth joint action,** the psychiatrist initiates the conclusion of the conversation, and the patient uses the open question about other important topics to describe her experiences during treatment in the hospital. She described these as terrible. Firstly, she had to wait a long time with her wound after the first suicide attempt and secondly, she felt devalued by cynical questions. After the second suicide attempt, although she felt offended by the psychiatrist's unsparing exposure of her eating disorder, she then found it very helpful because she was able to talk about it afterwards. At present, the patient feels taken seriously and expresses her satisfaction with the medical treatment.

Summary

1. In the first seven joint actions, psychiatrist and patient deal with the suicidal actions and in the last three with the present situation. In the first, the patient describes her emotional state, the termination of the relationship by her boyfriend and her efforts to maintain it. She justifies her dependence on him through her experiences of attempted rape and describes his abuse of trust. In the second, she describes her condition as "going crazy" and taking the drug overdose as "automatic." She also describes her first suicidal action, when she cut her forearm, as "automatic," likewise how she experienced eating disorders and also when she went on a spending spree. In the fourth they deal with the events of the 5 months between the first and second suicide actions. In the fifth, they elaborate on the patient's state of consciousness during the suicide attempts. In the first, the patient did not feel her physical pain because of the soul pain; in the second, she experienced herself as if in a trance. In the sixth joint action, the patient describes her feelings in the first suicide attempt as shame, and in the second as despair due to a betrayal of trust. The death consequence of the suicidal actions preoccupies her in the seventh joint action.
2. In the eighth joint action, they explore the patient's current relationship with her ex-boyfriend, and she also addresses her previous pregnancy and abortion. They also deal with this relationship in the ninth joint action, and the patient speaks of her release from her feelings of guilt and her empowerment. In the tenth joint action, the patient laments her treatment in the hospital, where she was treated cynically and unsparingly.

12.2.9 The Self-Confrontation Interview

What did the young woman think and feel when she talked about her suicide attempts, the rape attempts and her eating disorder? Viewing the video recordings of the interview together can provide some additional information here. In the **first section,** the patient reported that she had already told her story several times, so she no longer experienced it as intensely, but it still hurt: "It hurt me, but still I looked at it from a certain distance. It doesn't get that close anymore." In the **second section,** she clarifies her state of mind during the interview and finds a certain discrepancy in the way she gives herself: "I notice that I tell the matter more coldly than it has actually been for me." In the **third section,** the young woman adds a piece of information about the rape attempts that she did not reveal in the interview: "They were attempts. But it was always a hair's breadth away. There was almost nothing missing in all three cases. At six, it was with his hand instead of his limb. He did that on purpose so I don't have any evidence and that it can't be traced." She then reports on her openness in the interview: "I told everything here very spontaneously and openly. I didn't overthink it. I just said what I was asked. There was no blockage there in my mind." She says that it is still something to be overcome because it is a humiliation for

a woman to tell about it. In addition, she still has feelings of shame and guilt "Because I'm only just at the stage now where I'm reducing my guilt." She also mentions, which she did not report in the interview, that she was beaten in childhood. When asked, the patient confirmed that she felt comfortable during the conversation with her interviewer. In the **fourth section,** the young woman adds some details about her suicide attempt with medication overdose "After an hour I was foaming at the mouth and I felt the effects of the medication." "It had about the same effects as if I had been drinking alcohol. I just felt like I was drunk." In **fifth section,** the patient clarifies some time details about her history that the research assistant did not understand acoustically correctly. In the **sixth section,** the young woman complains that she is already tired and weary of telling about her crisis repeatedly. In the **seventh section**, the patient is challenged by the research assistant's comment that she is unaffected by her experiences "Unaffected – I've been telling this story every day for a week. It's not that it doesn't touch me. It's just that you get tired. I just want to finally switch off. It's blocking me – no. I just don't like it anymore." Also in the **eighth section,** the patient shows herself misunderstood and urges to move on to the next section. In the **ninth section,** the young woman adds why she called her ex-boyfriend during the hospital stay "I was just so angry… I called him because I wanted to have a conversation with him for once. For once, I wanted to tell him in no uncertain terms what the score was." In the **tenth section,** the young woman reveals another piece of information that she had concealed in the interview, "I also had a bad experience with my stepfather. He beat me a lot when I was a kid. I almost had to go into hospital for stitches once too, he hit me so hard. That's when I just got a phobia of men."

She then tells further details about the rape attempt, which she did not mention in the conversation "They (came) in pairs and pour(ed) drugs into the glass… You just don't have a chance at all. Especially when there's two of them. One just undresses you and the other holds you down. I was just pumped full of these drugs… It's just extremely humiliating… My life wasn't made of sugar… I just kept quiet." She then says that the repeated telling allows her to admit and report on everything "I could have just never told all of this at all. Or I would have just downplayed everything a lot. I would have just said that they touched me. But now it's starting to happen. I'm also now aware that it's just absolutely not my fault." In the **11th section,** the patient makes an observation that immediately leads her to reflect on herself "I just find it amazing how I present all this. Even though it's all been very bad, yet I always bring it with humor now. I just wonder where I get this optimism from." She adds "I'm proud to say that." Finally, the patient addresses her eating disorder, which is far from over "I've had that (the eating disorder) for a year now. I used to hide it. If I went to vomit, I always flushed first. Or it was my bladder was full. Or I was just sick otherwise. I've just had endless excuses. I didn't admit it. But I didn't really lie to the others, I lied to myself… When I still weighed 40 kg, I really started to get scared. But you also get out of this vicious circle once. It's just very difficult."

Summary

1. In the **first section,** the patient says she no longer experiences her history so intensely, but it still hurts. In the **second section** she finds a certain discrepancy between how she experienced it and how she gives herself. In the **third section,** the young woman adds information about the rape attempts. She says that she was very open about it but it still takes an overcoming because it is a humiliation for a woman to talk about it. She also mentions that she was beaten in her childhood. She felt comfortable with her interlocutor. In the **fourth section,** the young woman adds to the medication overdose, how she felt the effect of the medication. In **fifth section,** the patient has to clarify some time details about her history which the research assistant had not understood acoustically properly and she seems to feel uncomfortable.
2. In the **sixth section** she complains that she is already tired and weary of going on and on about her crisis, in the **seventh section** she shows herself challenged and wants to finally switch off, in the **eighth section** she feels misunderstood and urges to move on to the next section. In the **ninth section** she justifies her call of the ex-boyfriend during the hospital stay.
3. In the **tenth section** she tells how she was beaten by her stepfather and how two men tried to rape her. She appreciates the influence of the conversation and the self-confrontation interview because she could not tell all this before. In the **11th section,** the patient expresses appreciation for how she presented everything and pride in having said it all that way. This also allows her to talk about her still ongoing eating disorder.

Case 11

13

13.1 Suicide Story: Mr. Bindermann: Nobody Believed Me, Otherwise It Would Not Have Gone So Far

Kornelia Helfmann
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Somewhere in this cupboard there must still be the psychiatric drugs I was prescribed at one time, but I can't find them. I can't remember throwing them away either. Or maybe I did. They didn't do any good anyway; the doctors just wanted to label me as a psychopath. They were supposed to help with my tension, but none of the doctors ever believed that it was physical. I used to have problems with my back, but then I built up my back muscles, then it was fine. My back was fine, the doctors said, my blood values too, so they couldn't explain where the pain in my shoulder-neck area came from. But now it would be good if I could also take the psychiatric drugs, because I don't think that an aspirin and a tablet against the pain is enough. I have to take more and see what happens.

Nothing. When I look in the mirror, I'm startled at the sight of myself. White as the tiles here in the bathroom, dark circles under my eyes and my hair unkempt and matted. I feel ashamed of myself. I didn't make it into the shower last night, I was that beat, and now I stink. If only I hadn't gone snowboarding yesterday, then I wouldn't be so tired and wouldn't have had to endure the reproachful looks of my parents: yes, yes, you can have fun, they said, but not if you can't bear the consequences and get up the next morning and go to school. But I can't just study and sleep all the time, that's not possible, no one can stand that, why can't they understand? And it was my friends who persuaded me not to go straight home after snowboarding and to do some breakdancing with them. I enjoyed that, but it was stupid, that's why I'm so tired now. I overworked my body. The snowboarding was quite good for me; it relaxed my back, but overall it was all too much. I should have known.

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I have to search my parents' medicine cabinet after all, even though that's forbidden for some reason, but the things have to be somewhere. Ah, here they are. Next to my mother's headache pills. I had taken them for a long time when the doctors claimed that my illness had psychological causes. But they didn't help, simply because there were physical causes. But the doctors, those know-it-alls, were all incompetent and wanted to impose their opinions on me. I simply stopped taking them. There are only 15 tablets left, and the pack should still be full. My mother has probably taken them; she suffers from insomnia. I'm sure it's because she's so worried about me. It's my fault if she's not feeling well. It's all my fault.

How quiet it is in the apartment. If only I could have gotten up this morning. Got dressed and had breakfast, got out of the house and pretended to go to school, and when my parents had left for work, sneaked back into the house and gone to bed. But it just didn't work. This tiredness. It hasn't been this bad in a long time. And now there's no point to anything anyway. My parents said it couldn't go on like this. I'll never reach my goals. I wonder what the point of my life is anymore.

The pills I've been taking so far aren't working; it's like I haven't swallowed them. I have so many negative thoughts. The worst is that everything was in vain, all the effort I put in, professionally. I have no chance anymore because I will never make it to college in this physical condition, and if I don't make it to high school, I can't go on to study at college either. Then the only option left would be a physical job, and I can't do that either. There's no point to anything any more, because I no longer have a goal.

I will now swallow two more tablets for every negative thought. In addition to the psychiatric drugs, I'll take the painkillers and aspirin. When I have swallowed two tablets, I wait to see what happens. I don't have to swallow them all, but the pain should go away. So I can finally relax a bit and sleep. I got to bed too late last night, and this is what I get for it now.

The fact that I have disappointed my parents so much is also quite a bad thought. I'm now 24½ years old and haven't achieved anything yet; I still live with them and am financially on their pocket. On one hand, I understand when they say it can't go on like this; on the other hand they just can't imagine what it's like to be in this pain. The new mattress has helped; my old one was too hard and the new one is very soft, that has really helped a bit, but as soon as I get physical my body goes on strike. I don't like fighting it anymore. I can no longer manage to recover at night enough to be fit and pain-free to go to school the next day.

I'm on two more pills now. It's been three and a half years that I've had this battle with my body. Everything came apart then. My girlfriend had left me; I had three months of severe heartbreak; then I had mono; then I had problems with my wisdom teeth, which I thought caused this terrible tension in my shoulders and back and neck. The symptoms didn't improve when the teeth were pulled either, and then six months ago it turned out they were from allergies. I'm allergic to all oils. And to citrus, cayenne pepper and curry. I have to follow a strict diet, but the perfidious thing is the hidden oils in some foods, and some also contain extracts of citrus, citric acid for example. If I eat them without knowing that there are these harmful substances in them, I'm flat for two days, it's like a really bad flu with cramps and sweating. But it doesn't matter, the teeth are out, I'm dieting as best I

can, and yet my bodily condition doesn't improve. I guess I am a psychopath after all. I'm a failure anyway. The doctors were right, and my parents, who stuck by me for a long time, no longer believe in me. It can't go on like this, they said. But no one can tell me how it can go on.

I don't believe in myself anymore either. I managed to get through the vocational baccalaureate, even though it was incredibly strenuous, but today I don't know how I managed it all, I managed the apprenticeship before that; I still had that motivation, the ambition. I wanted to show everyone what I was capable of, but I absolutely wanted to study dentistry, to fulfil my dream. I can forget that now; I can't even manage school, let alone university. And the private high school costs a lot of money, which my parents pay, and it still costs the same if I don't go. It's not that I don't want to: I just can't, and my grades have gotten bad. They told me that I won't pass the semester and I can't continue, they won't let me anymore. My future has been taken away from me with this. And, even if I passed the semester, I'd be in my mid-30s by the time I finally started making money.

I can forget about getting a girlfriend with these prospects. But that's over now anyway. I'll never amount to anything. I have a weak body and a weak mind. Not only am I extremely tired physically today, but mentally as well. It's depression, I think. Because my future plans are gone, because nobody will give me a chance anymore. It's like I've been accused of: I'm not fit to live. A psychopath, a failure.

I don't know why these tablets don't work. I have now taken a total of 16. I haven't taken any medication for a long time, so they should work quickly; my body is no longer used to medication. It wouldn't be bad if I never had to get up again. I wouldn't care.

I have to put on a sweater quickly, I'm freezing. The sun is shining into my room. Next to the bed hangs a poster of this American snowboarder, Shaun Palmer. I would like to be like him. Not only is he insanely good, a real daredevil, he also does what he wants; he doesn't care what people think. Not like me. I'm the one who's being judged. I would like to have my room furnished differently, because the bed I had as a schoolboy is still there, and the desk is actually too small for me. But I depend on my parents: if they say no, I can't do anything. I've also considered working a job on the side and earning some money of my own, but my body won't go along with it. It's exasperating. It's a vicious circle.

I sit down on the edge of the bathtub so I don't have to look at my face in the mirror any longer. I look like a ghost. It's just no one believes me that my pain is from being in bad shape and not the other way around. They just blame it on my psyche; it's easier that way. How am I supposed to be able to concentrate and perform well with the pain? I am expected to do the impossible. I can't meet those expectations. I am probably a depressive person, as I was told, but then why didn't the psychiatric drugs help? I mobilized my last reserves, they are completely used up. Actually, I wanted to take a break to regenerate my body, but my parents were against it. I can never become symptom-free if I put my body through too much. With snowboarding and breakdancing I wanted to treat myself to something, I should have left it alone.

When I close my eyes and think of my future, all I see is a black wall. I take two more pills, even though I don't really want to. But this black wall depresses me. I used to have

a strong will, but I've lost it completely. The physical fatigue and the lack of a goal for the future, because that was taken away from me, now come together and take away all hope. I don't want to justify myself anymore for something I can't do anything about. I am rather a shy person and cannot assert myself, although I always had a strong will, otherwise I would not have survived because I was a premature baby. But this strong will has always helped me. Yet if someone disagrees with me, then I immediately doubt myself, so not always. But when my physical condition is so bad, and I no longer have a protective shield, then I can no longer defend myself. And although I like to be with people and enjoy their company, because that gives me a zest for life, because then I can also be cheerful, I immediately withdraw when there is a quarrel, I almost can't bear it. It's pointless anyway, this quarrelling; mostly it's just about trivial things that would be best left alone.

This tiredness! It's best I lie down in bed. I don't know how many tablets I have swallowed now: maybe 30, maybe more. Luckily all the tablets were white. I couldn't have swallowed green or red ones, I would have got scared. I still don't feel any effect, I don't even feel sick, but I wouldn't care if I fell asleep and never got up. That would be the best solution.

13.2 Suicide Analysis: Young Man "I No Longer Saw Any Point in Continuing to Live in This State"

Ladislav Valach

The young man, 24, says that a few days ago he swallowed a lot of pills and fell into a coma. He then woke up in the intensive care unit.

13.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

13.2.1.1 Medium-Term and Long-Term Concerns of the Patient

When asked what the reason was for being in hospital, the patient briefly describes his suicidal action and the reasons for it. In addition to the events during the days surrounding his medication overdose, he describes a number of long-term and especially medium-term concerns or projects that he considers relevant to his suicidal action. He has been concerned about his *"physical fitness" for* more than three years; reports his *"allergy"* (oil products, citrus fruits, cayenne pepper, curry) and the corresponding *"diet"* he has been on for more than half a year; his *"lovesickness*" from which he suffered for three months after the end of his relationship; of his *"Pfeiffer's glandular fever",* an illness he overcame after two weeks; of his *"pain in the neck area"*; of his *"problems with the back muscles",* which he had to build up three and a half years ago; his *"medicinal treatment" of* the tension (pain), which he discontinued two and a half years ago, after completing his vocational training (an apprenticeship with a baccalaureate); his *"visits to the doctor", "chiropractor treatment", "dental treatment" (*had his wisdom teeth extracted, in the belief that this

would alleviate his pain); his *"physiotherapy",* his *"sporting activity",* the hobby *"break-dancing",* to which he attributes his neck problems; his *"professional training" (*final exams in the trade school in the subject of mechanical draughtsman, professional baccalaureate, grammar school (in the third of eight semesters), he would like to study dentistry later). In addition, he was worried about his *"sleep*" – believing that his pain could come from his hard mattress, he changed it.

He also talks about his *"relationship with parents*". They finance his education at a private high school, and, when they found him back at home in bed instead of at school, they said that there was no point and it could not go on like this. The patient speaks of a *"quandary situation*". On the one hand, he feels dependent because he accepts the support of his parents although he does not want it; on the other hand, he is not able to earn the money himself because he feels weak and sick. He reveals the same feeling about his future. On the one hand, he felt unable to continue studying; on the other hand, he was too weak to work physically. As a result, he lost his *"self-confidence"* and his conviction that he could achieve his goals.

His main concern was *"…that I take a break now to regenerate my body so I can figure out what it is about all my tension and pain in my neck, shoulders and back. I want to fix all those aches and pains. Because that's the only way I'm going to be able to continue in school and finish it properly. And also then later in my studies, where the hurdle is then set even higher, that I can also pass there." ("Regenerate Body").*

The most important, all-embracing concern *"to live"* or *"to stay alive"* is seen by the patient only as a background for the successful achievement of his projects *"education", "fitness",* or *"freedom from pain",* which he sees as a prerequisite for the former. If this is not possible, he may depart from life. The advancement, the achieved fitness and freedom from pain are the elements of his *"meaning*". In addition, his parents must also confirm whether or not they see meaning in what he does. For this young man, *"seeing the future*" means fulfilling the requirements to achieve his goals. Another concern, revealed only during the process of dealing with his problems, was to *"feel understood,"* which was not the case at present. Neither the doctors, nor the parents made him feel that they understood him, quite the contrary.

The young man includes all these medium-term and long-term concerns in the description of the concrete course of his suicide action. He mentions one thought or action step in each case, to which, however, he expresses many background thoughts, albeit at a different point in the conversation, which one can assume were also present in one form or another during the suicide action and were thus effective.

▶ **Summary**

1. Along with his suicide attempt, the patient also describes a number of long-term and medium-term concerns in which he saw his action embedded. The long-term processes include above all his efforts for his "physical fitness", "health" as well as "education".

2. Long-term concerns will certainly include his relationship with his parents, but he currently addresses this only in the context of his as yet unattained desire for financial independence. Although he only laments his loss of self-confidence due to his lack of physical fitness, this could also be one of his long-term issues.
3. He sees the medium-term goals as "overcoming lovesickness", "sporting activity", "breakdancing", "dealing with food allergies", adhering to the appropriate "diet", "curing Pfeiffer's glandular fever", "coping with pain in the neck", "eliminating problems with the back muscles", by "building up the back muscles", "medicinal treatment" of the tension (pain), "visits to the doctor", "chiropractic treatment", "dental treatment", as well as "physiotherapy".

13.2.1.2 Short-Term Actions

Suicidal Action: Patient (P)

Cognition P: I was just in such a bad shape.

Allergies:

Cognition P: Sometimes you don't even suspect what all is in these products.
Cognition P: I may also have had some conceit that there was nothing like that in these products.
Cognition P (of Action P): For example, I bought a doughnut and didn't even think that it might contain something harmful.
Cognition P: I have known that I am allergic to oil.
Cognition P: I would not have thought, however, that there was still oil on the doughnut. Therefore, I have then also nothing suspected.
Cognition P: I felt bad after eating.
Cognition P: Then I felt that I was not motivated to work, that I went to bed too late.
Cognition P. I just made up all these things, again it was an allergic condition.
Cognition P: Then I couldn't concentrate properly at work either.
Cognition P (from action step P): I always had to change my position because everything was so tense.
Action P: I then went home to bed afterwards.
Action P: I couldn't do anything else.

Spinal Problems:

Cognition P (from action P): I still had exercises from physical therapy.
Actions P: I also did breakdancing.
Actions P: That's when I used to turn upside down.
Cognition P That's when it still crumpled my spine for a while.
Action P-: Then I couldn't stretch anymore.
Action P C: I then went to the chiropractor (C).

Action C P: He then stretched my spine again.
Action C P: They then told me that my back muscles were not okay.
Cognition P: I had the feeling that this all came from this sport, that it damaged me.
Action P: I then built up my back muscles again. That was about three and a half years ago.
Cognition P: The spine was then also good again.

Neck Pain:
Pain P: I then also had recurring pain in the neck area.
Cognition P: I then thought that this one must have been damaged from breakdancing.

Overall View:
Cognition P: But in addition, there was also this allergy and the discomfort with the teeth.
Cognition P: I think that all these three things together were too much for the body.

Tension:
Action P: I stopped taking medication for tension about two and a half years ago, after I finished my vocational baccalaureate.
Action P: Because I changed the mattress at home. I now have a soft mattress at home.
Cognition P: Therefore, the tensions have decreased somewhat.
Cognition P: I then had the feeling that I could do without again.
Cognition P: I just thought that swallowing medication wasn't exactly healthy either.
Action P-: I haven't actually taken any medication recently. So in the last two years I haven't actually taken any medication at all.
Cognition P: Because I have always in the last three and a half years never seen a future.
Cognition P: I was just totally physically overtired.
Action P: On the one hand, I went snowboarding on Sunday.
Cognition P: That's probably where it kind of got me again.
Cognition P: I was just very tired and tense again on Monday.
Action P-: I just couldn't get up in the morning.
Cognition P: I just felt really tired.
Cognition P: I then became depressed as well.
Cognition P: I have been thinking about my future.
Cognition P: I simply became aware that in my physical condition I could not do any work, nor could I perform any mental work.
Cognition P: If I had to give up school, I would have to switch to a physical job. But this would be even more impossible in my physical condition. That would be even worse. I already feel so physically bad. And what else is there to do? There's not much left.
Cognition P: (I also) blamed myself: (that I was) simply weak, that I was a psychopath. Because that's what the doctors told me at the beginning.
Cognition P: Because I always believed that it wasn't me. And now it turned out that it was nevertheless, that there were no other reasons.

Cognition P: It's just a desperation. It's not that I don't want to live anymore. I want to do everything so well, I want to achieve the goals I set for myself. But my body just won't cooperate. It's hurting me, it's bothering me.
Cognition P: I just lost confidence in myself, in what I had set out to do. I just had to give up the fight against my own body. Yes.
Cognition P: I said I'm going to stay home for two more hours now, and
Cognition P: that I will then go to school.
Cognition P: I had really intended to do that, actually.
Cognition P: I no longer saw any point in continuing to live in this state.
Cognition E: But then my parents (E) noticed that I was not going to school again.
Action step E P: Then they said it doesn't make sense that way,
Action step E P: and that it could not go on like this.
Cognition P: I have also had the same feeling.
Cognition P: It doesn't work that I'm always totally tired, and…
Cognition P: that I don't go to school because of that.
Cognition P: I just felt then that it really didn't make sense anymore that way.

Reproaches: (Assumption of Responsibility)
Cognition P: Certainly, I also blamed myself.
Cognition P: Because I felt like I had this allergy under control now.
Cognition P: The tension caused by the teeth has also improved, as I had them pulled six months ago.
Cognition P: Then I already hoped a lot after the teeth.
Cognition P: It didn't give me what I really expected, though.
Cognition P: It helped me a lot, but that painless state was just not achieved.
Cognition P: I was hoping that if I could also get the allergy under control that I would then be 100% pain free.
Cognition P: I just meant that I would be fine if I gave up these products.
Cognition P: But that wasn't the case.
Cognition P: Because I was still taking vitamin tablets at the time that contain a product, citric acid, that I don't tolerate well.
Cognition P: Because I was not in such good physical shape, I took my vitamins every day so that I would feel better, so that my tensions would be relieved.
Cognition P: But my tension remained.
Cognition P: I just thought that since I don't eat anything bad for me anymore and the teeth were pulled, that it could only be me.
Cognition P: I thought now that I was just weak, that I was a psychopath.
Cognition P: Because that's what the doctors told me in the beginning.
Cognition P: I just thought that I am now really as they had imagined.
Cognition P: Because it can't be the teeth and the allergy anymore.
Cognition P: I thought that I just had a weak body, and therefore when I was tired, all these reactions would just be triggered.

Cognition P: I found, therefore, that all this no longer made much sense.
Cognition P: Because I always believed that it wasn't me.
Cognition P: And now it turned out that it was nevertheless that there were no other reasons.
Cognition P: Simply that I am not as physically fit as a normal person.
Cognition P: That I can't do my assignments for five days, and that I can't then do sports on the weekends.
Cognition P: You don't like to hear that (that mentally, that something is wrong).
Cognition P: I just don't like to hear people tell me I'm not fit to live.
Cognition P: I don't think it is. I also believe that this is not the reason.
Cognition P: You could say that it has now been confirmed.
Cognition P: But it's not simply an affirmation. It is simply a despair.
Cognition P: It's not that I don't want to live anymore.
Cognition P: I want to do everything so well, I want to achieve the goals I set for myself.
Cognition P: But my body just won't cooperate.
Cognition P: That pains me, that occupies me.
Cognition P: I've been thinking about what to do now.
Cognition P: I wanted to go to school but felt so weak.
Cognition P: Then I simply thought that I would now take a relaxation tablet.
Action P: I also took another aspirin to build myself back up.
Cognition P: I hoped that would make me feel better.
Cognition P: But then I thought that it was not done with tablets alone.
Action P: Then I have therefore swallowed too many tablets.
Cognition P: I then told myself that I will now take more and I will see what will happen.
Cognition P: And then if I don't get up, then it's not a big deal.
Cognition P: I just didn't care what was going to happen.
Cognition P: If someone had told me that I would not have to attend school for a while and could devote myself fully to my health, it would never have come to this.
Cognition P: I was standing in the bathroom thinking about whether or not I should take more pills.
Cognition P: I just let all the worries of the last three and a half years run through my head.
Cognition P: Simply the fact that never improved anything, I could not get out of my head.
Cognition P: Every time a bad thought crossed my mind again.
Action step P: I took two more tablets again.
Cognition P: I was just waiting for something bad to pop into my head.
Cognition P: I had to really focus on the fact that I was still having bad thoughts.
Cognition P: I just had to remember my bad times.
Cognition P: To justify that I'm really gulping down these pills.
Cognition P: Because I already lacked the courage.
Cognition P: I didn't really want to do this.
Cognition P: Yes. Just new bad thoughts all the time.
Cognition P: I had to try really hard to keep having new bad thoughts.

Cognition P: But these have been on my mind many times.
Cognition P: And that's why I didn't find it so hard to remember.
Cognition P: I just thought it was so worthwhile.
Cognition P: … this certainly took 20 min, even half an hour.
Cognition P: There was nobody there (in the house).
Cognition P: It has been confirmed that no one understands me. Neither the parents nor the doctors,
Cognition P: (got me) upset that people are ruling over me.
Cognition P: Just really upset me that people think about me that I just don't want this, that I'm just a psychopath.
Cognition P: This very opinion that people were trying to force on me, I began to believe in that moment. I began to think that it would probably be me anyway.
Cognition P: I was just thoughtful.
Cognition P: I just thought about the consequences
Cognition P: and was hoping these wouldn't be so bad.
Cognition P: I just wondered after each tablet if I should take more.
Cognition P: But the thoughts I had about not being believed anymore -
Cognition P: I just thought that this way I could escape all this pain.
Cognition P: I already looked at what kind of pills I take.
Cognition P: I have had two aspirin and 15 tablets of a medicine and 20 relaxation tablets for the back muscles.
Cognition P: I have thought that these are not so strong tablets, and therefore I have to take a larger amount.
Cognition P: If I could just fall asleep, this would have been fine for me.
Cognition P: But if not, I wouldn't have wanted it.
Cognition P: They were white tablets that weren't too bad to swallow.
Cognition P: Now if they had been red or green pills, I wouldn't have been able to swallow them. I was afraid of it.
Cognition P: Suddenly I felt like there were enough.
Cognition P: I then thought that I would now go to bed.
Cognition P: But then I had the feeling that I would then feel sick, and that I would vomit, and that I would then die in a very cruel way.
Cognition P: I was actually waiting for that.
Cognition P: I wasn't hoping for that, of course.
Cognition P: Everything turned out quite differently.
Action step P: I then fell asleep in bed and
Cognition P: I was glad then.
Cognition P: I just imagined it differently.
Cognition P: I thought that when you take pills, you always feel successively worse.
Cognition P: But I didn't get sick at all and so I thought I needed to take more.
Cognition P: But even when I had taken them all, even then I didn't feel sick.
Cognition P: I then thought that all this is of no use either way.

Cognition P: I said to myself that maybe it's better this way.
Action step P: I definitely went to bed then,
Cognition P: not because I was sick, no, because I just felt tired.
Cognition P: But apparently they still worked. Yes, that's how it was.
Action step P: I just went to lie on the bed.
Cognition P: I felt like I was doing well
Action step other P: and went into a coma; fell into a coma, as I was told.
Action others (parents, emergency services) P: Then I ended up in intensive care.
Cognition P: And just all of a sudden I was in intensive care.
Cognition P: I still knew everything then (what had happened).
Cognition P: When I woke up I realized that the pills didn't work after all and that I am now here in the hospital.
Cognition P: I also immediately remembered what I did.
Cognition P: I then thought that it still didn't work out.
Cognition P: I was surprised. I even thought if I was in heaven now, because everything was so white.
Cognition P: I wasn't necessarily pleased (that I'm still here), but I didn't mind either.
In addition to this description of the external and internal processes of his suicidal action, the young man also comments on his present. These are partly assessments of his situation, partly a continuation of his concerns, which also played a major role in his suicidal action.

Present:
Cognition P: "I am now already glad that I did not die.
Now I have certain hopes for the future again that I have created.
Because apparently I can interrupt the semester to focus on my physical pain."
Cognition P: "I've actually wanted to do this for quite some time. Even after I finished my vocational baccalaureate, I wanted to do this. But by getting a better bed and feeling a bit better, I got my hopes up again and I told myself that maybe it will work out that way. But I've now just realized that it doesn't work like that after all."
Action parents: "And now they have said that I can skip one semester to fully focus on my physical condition."
Cognition P: "I am very happy now. This is exactly what I had always wanted. That was also the trigger for me not wanting to go on living that morning. I just knew I wasn't going to get that chance again. If someone had told me that morning that I wouldn't have to attend school for a while and I could fully devote myself to my health, it never would have happened. I would have just said that's what I'm going to do. I would have seen a future again at that point."

Dealing with the Next Crisis:
Cognition P: "I will simply try to assert myself more now. I'm just going to say that I want it this way and that way, and not any other way. I just don't want to be dependent on

other people who have an incorrect view of me. Because I am convinced of myself that I can do it if I have the right physical condition. I'm just going to pick up the phone myself, and say I'm not going to come back for a week now because I need to cure my body first. I'll just have to follow through myself."

Cognition P: "Today I can go home again. It is mainly my parents who have now given me this new chance. They probably really didn't understand me before, although I thought they would. They probably just thought I didn't want to do it. The doctors just felt like there was nothing wrong with me. But there is something wrong with me and it's just my good shape."

Back Tension Treatment:

Cognition P: "(Soon) I have the first appointment with a specialist for back tension. I do hope now that he knows something about his subject. I don't doubt that he is technically on top of his game. But I just hope that he understands me, that he can relate to me and understand me. That he can just figure something out so that I can then get better. I understand that it doesn't happen overnight. That it may take half a year or more can also be. But if it makes my suffering go away, then I don't see any problems at all."

Cognition P: "I don't know the (doctor) yet. But I am again very hopeful. Of course, I'm not very hopeful because I know it's very difficult to cure my ailments. I have seen that in the last three years. No one has managed it then either. I am already skeptical. But I'll just go and see him. And if he can't figure anything out, then I'll just go to the next one."

The Psychosomatic Status of Pain and the Patient's Difficulties:

Cognition P: "That I'm simply believed that my pain is not coming from my bad condition, but that my bad condition is coming from my pain. That's the whole point. The pain just makes me tired. And then I just get to a state where I don't see it so rosy anymore because I'm just tired and I'm in chronic pain. The previous doctors just found that I wasn't happy with my life and that physical pain would develop from that and therefore I was a psychopath. When in fact it's just the other way around."

Cognition P: "Once you have this pain, then you tense up inside and the tension certainly doesn't go away. This leads to chronic pain. Under these pains it is then also difficult to concentrate. The pain is always there and does not go away. And if you can't concentrate because of the pain, then you can't study anymore and then it can go downhill. I knew that. It went downhill then, too. I was also aware of that. But I just didn't have the courage to fight it forever. But it wouldn't have been so bad if I had still believed that it would turn out all right. But in the end I didn't believe in it either. As long as I believe in myself, I can still fight the pain. But when I stop believing in myself, I let myself fall and end up in depression."

Cognition P: "I am of the firm opinion that there is no psychological background in my case. But if others then tell me that it is nevertheless so, then I don't want to accept it. But if someone now says that it is, for example, 50%, then I can accept it."

Cognition P: "If it's just a percentage, then it doesn't bother me at all. Even if it eventually comes down to me being a depressed person by nature, then I accept that. If they can help me, then any means is fine with me."
Action Doctors: "They've prescribed me psychotropic drugs before, too."
Action P: "I took those then over a long period of time."
Cognition P: "But nothing changed then. But then I saw that this is probably not the reason. I am not averse to being treated by the psychiatrist. But it has to be of some use, otherwise I can save myself the trouble. I'm just a little afraid that then people will label me on that."
Cognition P: "I would also like to say that I would be interested in being able to talk to other people with the same back pain. Maybe one could find other ways to cure it that way too. Because I also don't know anyone who is suffering from this disease in particular right now." ◄

► **Summary**

1. The patient describes the actions of his suicide attempt and makes many reflections on his past and his future.
2. In his narrative, the action of suicide gives him a framework for describing other events. He speaks of his allergies, spinal problems, neck pain, tension, of his gloomy outlook "because I have always in the last three and a half years never seen a future", his complete physical fatigue, his depressive states, and self-doubt "I also reproached myself that I was weak, a psychopath".
3. The patient describes his suicidal ideation, his contact with his parents, his taking of pills afterwards and his waking up in the intensive care unit.
4. He also expresses thoughts on the present and how he will deal with the next crisis, plans for back tension treatment, and his struggles with the issue of the psychosomatic status of this pain.

13.2.2 Problems of Action Organization

It seems at first to have a certain plausibility that the young man, out of despair over his poor condition and even pain, questioned his overriding goal "to live" and, in fighting it, took the risk of not waking up. The short-term relief of pain by abandoning the existential goal "to live" is a very common and fatal problem in the organization of action in suicide: the hierarchy of goals is incorrectly perceived and implemented. This presupposes other errors of thought and action, such as the separation of the person who lives and another who feels pain and the processes of eliminating pain and feeling pain-free (the unity of the action organization of different action systems is not respected). Moreover, this requires the conviction that all possibilities of action to relieve pain have been exhausted, and death is the only option left. The young man describes the transition from trying to relieve pain (while simultaneously not touching life) to ending life (from a short-term goal to incorporating a long-term concern). However, a closer look reveals further problems of action

organization. The young man set up a situation for himself that he could not resolve. On the one hand, he put himself under pressure with his school attendance, which he did not dare to interrupt or even change; on the other hand, he did not want to give up his sporting leisure life and felt that if he could not do both, he was not a full person. However, the resulting physical discomfort prevented him from attending classes. It is as if he needed the pain to take time off from attending school. Again, the organization of different action projects is not in harmony with each other. Our everyday thinking would suggest that one might subordinate other projects to this goal of "learning" if studying is very important to one. This is especially true if recreational sports overwhelm one not only in terms of time, but also in terms of strength. Moreover, the young man does not seem to gain any feelings of success for his studies from these sporting activities. This would also be a task of optimal organization of several projects. The patient also complains that he is not understood, or rather he did not feel understood, neither by the doctors nor by his parents. It could be suspected that he does not know how to organize his encounters with the doctors and with his parents in terms of his projects and his goals. The parents do not comply with his wish to interrupt high school until after he has tried to commit suicide. Apparently, he was unable to clearly and credibly communicate the seriousness of his request. The problems in organizing action were also evident in the suicidal action itself. The young man describes how the intention to die was not sufficiently strong to take an overdose of medication and how he motivated himself to take more pills by figuratively evoking his difficulties. Again, a short-term annoyance, even if the discomfort and his dealing with it lasted several years, is turned into a long-term concern to "live" in question. Rather than using the poorly formed intention to die to rethink that intention, the patient tries to overcome it with anger at his inability to function optimally: "Every time another bad thought crossed my mind, I took two more pills again. I was just waiting for something bad to pop into my head."

▶ **Summary**

1. The problems of the order of action show themselves in several ways in this patient. First is the thought of coming to freedom from pain through death. This thought comes from the inability to see the concern "to live" as superior to all others, and from dividing oneself into one person who is in pain and must die and another who can then enjoy the freedom from pain gained.
2. The young man conceives of a situation as insoluble, since he cannot arrange the goals of his professional training and his recreational sport in a hierarchy.
3. The patient also complains that he is not understood by the doctors or his parents. This usually arises when one does not know how to organize his encounters in terms of his projects and his goals. It was only through his suicide attempt that he was able to successfully communicate his desire to interrupt high school.
4. He also shows the problems of the order of action in the actual overdose. His intention to die, to give up a long-term concern, was not motivating enough, so that before each next tablet he had to motivate himself additionally by a failure or problem image, by short-term states.

13.2.3 Consciously Prepared or Spontaneously Undertaken?

The patient describes how his suicidal intention developed slowly over years out of his despair, his suffering and his inability to get closer to his goals. First because he was in pain, then because he could not see a future, and finally because he did not feel understood. Just before his suicide attempt he said he just wanted to stay in bed for a few hours, then it turned into the realization, "my life can't go on like this" and when he was told this also by the disappointed parents who believed him at school and found him in bed, he resorted to the pill overdose. Thus, his suicidal request can be counted as a conscious preparation for suicide, and the disapproving statement of the parents, in turn, as a spur to spontaneous action. His way of taking the tablet overdose is also composed of these two different control processes. He wanted to die and take the tablets, but he had to remind himself of a horror image before each individual tablet in order to induce himself to take each further tablet "spontaneously".

▶ **Summary** The change from a life-sustaining project to a suicide project is described by this patient as a "both and" or "as well as" steering. He considered the suicidal action but still felt validated by his parents to do so. He wanted to take the tablet overdose but had to motivate himself additionally by emotional images before taking each tablet.

13.2.4 Problems of the Action Monitoring Processes

How did the young man's consciousness or attention, emotion, and sense of pain function in relation to the suicidal processes? The first thing that stands out is how the patient motivated himself to take more pills at his overdose by consciously evoking, or remembering, bad thoughts and experiences. Monitoring the current situation he was in did not lead him to continue the action he was engaged in – overdose tablet swallowing – so he had to help himself with negative emotional memories and negative future feelings to continue "Because I already lacked courage. I didn't really want this at all". This could also have a deeper meaning because it points to how the young man deals with his own conflicts. He didn't really want to die, but he forced himself to. Perhaps one could further suggest he didn't want to study, but he forced himself to. The severe tension and the resulting pain would suggest that. One could think of it this way: the young man did not take the information, "high school is not for me" and kept trying. He also did not perceive the emotional feedback, "learning doesn't suit me, I don't feel comfortable, I don't like it" and continued to attend school. Finally, the pain reported "this way hurts me", but the patient did not want to perceive this and did not change his projects. Actually, monitoring processes – to put it simply – are there to be used to draw action consequences. Only in exceptional cases, such as when one's own life or the lives of the next are threatened, can these monitoring processes be "switched off". However, everyday processes cannot be stylized into

existentially threatening processes. This is conventional wisdom and subjective views may differ. It must be remembered, however, that processes of action, like many other processes in their determination, are not to be read from a subjective point of view alone, but their social significance must also be taken into account. The scientist must integrate all these ways of looking at things and represent what is happening in a systematic way. The patient's statements in the self-confrontation interview also provide information about his monitoring problems. Asked to describe his thoughts and feelings during the interview, he says: "I don't really know how to describe the feelings".

► **Summary**

1. The patient describes how he switched off his monitoring when he overdosed on tablets. He thinks he lacked the courage to do so and actually did not want to die, so he summoned bad thoughts to continue the act.
2. Current emotional monitoring was replaced by feeling recall and by prospective feelings (emotional anticipation of future problems).

13.2.5 Problems of Action Energization

The patient does not describe how he was motivated to learn and energized by the images of being a dentist, being able to do his dream job, and enjoying all the comforts of a life as a dentist. He also does not relate that thoughts of recreational sports provided energy for his daily life. He does, however, describe in great detail how, when he overdosed, he drew the energy necessary to achieve an unwanted goal from the memory images that kept his suffering in front of him. He could not generate the energy to learn. In addition to pain, the patient complained primarily of exhaustion, weakness, lack of energy, etc. The emotional power of his goals was too weak to adequately energize his projects. He believed mainly in the energy of his fitness, which he tried to work out, but did not talk about the possible energization of action through his feelings.

► **Summary**

1. Closely related to the problem of emotional monitoring of the patient is the problem of energization.
2. The patient complains about his lack of energy.
3. He draws his energy for learning and for his daily life neither from his leisure activities nor from the joy of his future profession.
4. He is only convinced of the physical energy of his fitness, which he cannot achieve.
5. To self-destructive action, on the other hand, he may be energized by emotional memories and fears of the future.

13.2.6 Suicide and the Interactive and Collective Action

The young man spoke at length about his own efforts to cope with his health problems and when he thought he had reached his limits, he overdosed. However, there are also several references in his narrative to how important acting together was to him and how crucially this even played into his suicidal action. He reported his heartbreak after a relationship ended, which he counted among his problems motivating the suicide attempt. He did not feel understood by doctors or his parents. Doctors found little or no physical problems to explain his pain. The young man did not speak much of his parents, but when they found him in bed when he was supposed to be in school and said that made no sense, the patient adopted this interpretation and proceeded to attempt suicide. When they then subsequently agreed that he could interrupt high school, recuperate, and then continue with their financial support, the patient felt that he had reached the goal of his desires, which he apparently could not achieve by other means. The young man also articulated this problematic when he drew his lesson from the events surrounding his suicide attempt. He said, *"I'm just going to try to assert myself more now. I'm just going to say I want it this way and I don't want it any other way."* Collective action and its role in his life is also addressed by the patient in other statements. Achieving his independence is a long-term concern of his: *"I just don't want to be dependent on other people who have an inaccurate view of me."* In addition, he says it is very important to him that others not doubt him and even stigmatize him, which could happen in the case of his accepting he has psychological problems he should deal with. Finally, he also professed appreciation of joint actions and said "… *that (he) would be interested in being able to talk to other people with the same back pain as well"*.

► **Summary**

1. The young man, while linking his suicidal action to an effort to cope with his pain, hints at much shared action with others that he considers important to his action.
2. He had to cope with his heartbreak and felt misunderstood by parents and doctors. Immediately before his suicide attempt, he heard his parents' disappointment in him.
3. The patient states that his important concern is to be self-reliant and independent of other people.

13.2.7 The Young Man's Conversation with a Psychiatrist

The different psychiatrists often completed different psychotherapeutic trainings and are also characterized by different philosophies and strategies of forming relationships and conducting conversations. This does not necessarily lead to different data that they collect

in the conversation, but the presentation of the history of the counterpart shapes this in any case.

The **1st joint action** of the psychiatrist and the young man is initiated by the psychiatrist formulating the joint task and seeking further specifics from the patient. He is interested in learning more about the young man and specifically, *"What is the reason you are in the hospital now?"* The patient picks up on this and describes in a few specifics what happened. He was in poor health, had seen no future in three and a half years, saw no point in continuing to live in this state, had taken many tablets and had slipped into a coma. The joint action is then framed in question-answer sequences. Why was the patient in bad shape? – he got an allergy – how does the allergy manifest itself? – How long has he had the allergy? – how frequent are the fever attacks? From the many details the young man gave when asked about his poor condition, the psychiatrist picks up on the allergy and probes for more details. This, however, is because the patient believes the allergy to be the explanation for his many problems. In the **2nd joint action,** they clarify the patient's educational background and educational and vocational goals, as the psychiatrist is puzzled that the patient attends a middle school despite his age – 24. In the **3rd joint action,** the psychiatrist wants to steer the conversation back to the day of the suicide attempt, but asks if this was the first suicide attempt. The patient answers in the affirmative with a short sentence and again describes his many complaints that plagued and annoyed him. The psychiatrist then wants to know if the patient was on medication and keeps steering the conversation back to the medication, even though the patient would rather talk about his struggles with his problems. This is certainly significant, he says, because the patient is trying to commit suicide by overdosing on medication. In the **4th joint action,** the psychiatrist asks the patient to describe the critical day. The patient describes his condition as fatigue and tension. He uses the term depression for his mental state. Again, the psychiatrist proceeds according to the rules of his profession: how did the depression express itself? Which thoughts? What feelings? The answer, *"I simply lost self-confidence in myself," is* cleverly reflected back by the psychiatrist as: *"You gave up self-confidence…" in order* to reorient the young man from his victim stance to a doer. The psychiatrist then doubled down by asking if the patient had also blamed himself. The latter then described in detail again his complaints and his confrontation with them, and finally also his despair because nothing helped. This worsened when he heard the opinion that he was not struggling with physical problems but rather with psychological ones. The psychiatrist introduces the **5th joint action** by observing that the patient is very moved when he reports this despair. The patient then specifies his fears and anxieties, he is not fit as a normal person, he is not fit to live, his body is not cooperating. In this state of actualization of feelings as on the suicide day, the psychiatrist again directs the patient's attention to the suicide action. The psychiatrist tries to ask in more detail about the patient's statement that he had taken the overdose because he felt too weak, to which the young man replies. In addition, he wants to know how long this lasted and whether the patient was alone. Here the subject of

an option other than suicide presented itself, which the patient denies, however, because he did not feel understood by anyone. The psychiatrist also asks about other characteristics of the suicidal action, whether the patient was agitated or calm, whether the action was automatic or he could control it and reversal would still have been possible. In the **6th joint action,** the patient depicts the time when he stopped taking the pills and how he fell into a coma and woke up in the hospital. After that, in the **7th joint action,** the psychiatrist directs the young man's attention to the present. The patient expresses great satisfaction because he achieved what he wanted. He can now skip a semester of school and devote himself to his problems, which would not have been granted to him before the suicide attempt. The psychiatrist wants to discuss with the patient the possibility of contacting other people in the next crisis, but the patient does not take this up. He does have an appointment with a back specialist and he hopes that he will understand.

The psychiatrist makes the patient aware of his important theme of "being understood" **(8th joint action).** The patient narrows this theme down to how far his problems have physical or psychological causes. The psychiatrist enlightens the young man that it could be a circle and that these two are so related.

In the **joint action (final section)** the psychiatrist tries to win the patient over to his recommendations. On the one hand, the patient should work with a rheumatologist, but on the other hand, he should also seek psychotherapeutic help. The psychiatrist offers the young man concrete help for this.

► **Summary**

1. In the 1st joint action, the psychiatrist and the patient establish their joint task in conversation. The patient tells of his suicide attempt, how he felt bad for three and a half years, and attributes his poor condition to an allergy, which they explore in detail. In the 2nd joint action, they discuss the patient's educational background. In the 3rd joint action, the young man again describes his discomfort and his suicidal action, and the psychiatrist inquires about the medications the patient was taking. Also in the 4th joint action they deal with the critical day of the suicide attempt and the psychiatrist tries to move the patient from a victim attitude to an acceptance of responsibility.
2. In the 5th joint action, the psychiatrist picks up on the patient's present feelings, and the patient reveals that he is not fit like a normal person: not fit to live, his body is not cooperating. The patient complains that he does not feel understood. In the 6th joint action, the patient tells about the time after taking medication and his time in the intensive care unit.
3. In the 7th joint action they talk about present. The patient is satisfied because he achieved his goals (interruption of high school). In the 8th joint action they take up the topic of how far his problems have physical or psychological causes. In the 9th joint action they discuss psychotherapeutic help for the patient.

13.2.8 The Self-Confrontation Interview

Asked what the young man thought or felt during the interview, he tells us in the **1st section** that he tried to be brief, was very focused to remember what he felt at the time, also tense. We know from his interview that being tense is his basic attitude. In the **2nd section** he repeats the description of his physical symptoms, stressing how bad they were and that this was beyond anyone's imagination. Moreover, in the interview, he is careful not to get into too many details so that it does not become too complicated. The young man states in **the 3rd section** that he was sad when he told about his problems after eating a doughnut. Above all, "because *I felt that after all I was the one who was not fit, that it was simply me who did not like to perform. That I am simply the guilty one.*" In the **4th section,** he adds to his information from the interview that at the beginning of last semester he got a B four times and he did not manage to make up for it. In addition, he emphasizes how he had to fight his body, struggled, and still could not perform physically. Interrupting high school to recover was not allowed by his parents. The young man could not talk about feelings when he described this difficult situation. Repeatedly asked by the interviewer about his feelings (what did he think and feel?), the patient shows himself helpless: *"I don't know exactly how to describe the feelings."* **(5th section).** He again describes the situation he was in at that time, what problems he had to deal with, about his inner experience, on the other hand, he only says: *"I just had tremendous willpower and bit my way through everything."* He describes the critical Monday again: *"The hopes that something could change were simply no longer there on the last Monday. … The body condition is not improving, and I don't get a chance either. I simply asked myself about the meaning of life. … I looked at myself as a failure, because I just couldn't get through it the way I had been able to at the vocational school."*

The young man also reiterates in the **6th section** his belief that his physical condition was hindering his performance. The bad physical condition would come from the breakdancing, the allergy and his teeth. He said that he wanted to compensate for this with a great effort of will. In the **7th section,** the young man completes his suicide story with the information that in the last two to three weeks he knew that his grades would not be enough to finish the third semester. So he felt less motivated but wanted to continue attending school to absorb a lot. However, he felt that he needed to relax and unwind over the weekend, which he did best while snowboarding. He also visited friends, got talked into breakdancing, and went to bed very late on Sunday. He knew these activities would stress him out and get him down, but he wanted to treat himself to something to boost his morale. However, he couldn't fall asleep and felt very tired on Monday: *"this all just got to be too much once."* He again summarized his situation immediately before his suicide: *"Then there was also the fact that the parents were difficult that morning. That's when it just wore me out. The fatigue, the tension, the future that was already clear in advance that it wouldn't be enough and that I wouldn't be allowed to repeat…"* The young man once again summed up his thoughts. He thought that he could overcome the pain with his will if he had a future, school and studies, in mind. But now, in his opinion, the future was

taken away from him, *"…there was just suddenly nothing on one scale and the scale tipped to one side that morning. And then it just went off."* The young man continues to deal more with his suicide in the **8th section** and less with the thoughts and feelings he had in the interview. He has nevertheless come to the opinion that *"(there are) two different kinds of fatigue. There's a fatigue when you don't have a future anymore – then you get tired. Or you can get tired for physical reasons. Before, I always got tired for physical reasons. I have always had a goal in mind. On that Monday I had also been physically tired. But on top of that, I didn't have a goal in mind. That's when I added to it… It was just now not just a physical fatigue, but a mental fatigue as well."* He realizes that it's a new thought that he wasn't as consciously possessing in the interview, *"But I didn't realize until now what the actual reason had been. I realize that it wasn't just physical fatigue that caused me to slip into a depressive phase that morning. No, it was mainly the lack of a goal that drove me so far. This aimlessness just got to me. This was the trigger for me to take these pills." "But only now, at this moment, has it occurred to me what actually really happened."* In the **9th section,** the patient tries to clarify the hypothesis he took from a conversation with a doctor he was a psychopath: "*… when I was in depression on Monday morning I kept telling myself that I was not a psychopath. Now the doctors have confirmation of their theories, but I know it's not what they think it is with me. I know that the trigger for my depression was the physical pain."* He also reports how he feels attacked by this insinuation: *"it just annoys me when I have to justify myself to other people all the time."* He expresses a dichotomy that on the one hand, *"…it's important to me that people understood me and believed what I was saying. How other people interpret it, I could care less."* And on the other, he emphasizes, *"I don't really need anyone to understand me. I just want to eventually have confirmation that I was right."* In this passage the young man also formulates his view in which the unity of seeing himself as the agent and at the same time as the focus of his action breaks down, as is the case with many suicidal people. We formulated this as an action problem. The patient states: *"Even if I had died from this overdose of tablets, everyone would have said that the cause of my death was psychological. The whole world would have believed that I was a psychopath. But I myself would still have believed in myself, even though I might not be here now, but in heaven. I would just laugh at everyone. Because I would be convinced that it is how I feel, and not how it appears to everyone now. Because it all wouldn't have come to this if people had believed me for once."* The young man doesn't see himself as a life he can shape, but as someone who has to assert himself with his strong will: *"I've also just been asserting myself for three years now. With this incident on Monday, it has also been shown that I have not been able to kill myself. I am very glad about that. That's when you saw that I'm still a strong person. This is not the first time that I should have died. When I was born, this would have been the case if it had gone off normally. I wouldn't have survived because I was premature. Even then, I guess I had had some will to survive. I achieved that, too."*

In the **10th section,** the young man formulates a thought that is important to him, plays a leading role in his life and was even a decisive factor in his suicide: *"As long as I have a goal, then you can take all the negative influences of the environment. That's how most persons*

feel. But when you no longer have a goal, then you no longer have a shield." When asked how the patient felt about talking about the term "psychopath" he said, *"I don't really care if someone tells me I'm a psychopath. No, I do care. But if I have a fit body, then someone can tell me that and it doesn't affect me."* The patient indicates several times that he is a lonely fighter who likes to associate with others but can assert himself with his strong will: *"I've been fighting my way through my whole life."* In the interview, he also denies the option of talking to others before committing suicide. The psychiatrist asks, "*While you were standing in the bathroom, didn't it cross your mind that you could still contact someone because you were feeling so bad?* Replies the young man", *"No. Because it has been confirmed that no one understands me."* However, in the self-confrontation interview **(11th section),** he says, *"If someone had come and told me that they wanted to discuss my problem with me now, that they really wanted to get to the bottom of it, that would have saved a lot of things."* When asked how the patient is now, he replies *"Everything is so tense at the moment.* "This seems to be a condition that is with him all the time. After all, he says, *"I have been struggling all my life."* In the **12th section** the patient elaborates on his feelings: *"It is the hopelessness that makes me helpless. My aim is just taken away and I am not understood. What one (he) says, no one believes."* He further clarifies the victim stance he felt he was in, *"If you want to destroy someone, you have to make him physically weak. If he is weak physically, then he becomes weak mentally. And then you can destroy him."* In the **13th section,** looking at the part of the interview about the last moments before the overdose, he says, *"It was just kind of a balancing act in that moment. I was just always wondering whether I should be doing this or not. Being misunderstood on the one hand and aimless on the other allowed me to slip to that side. That was always going through my mind. Someone should have supported me from the other side. That would have been the goal. If someone had understood me, then I wouldn't have gone flying down the mountain. I certainly missed that."* This mental back-and-forth was then followed by concrete feelings about the suicide action: *"I was already afraid. But this fear of dying seemed like a way out. It just seemed like the best solution at the time. I can say it over and over again. I just hadn't had a goal anymore and I wasn't understood by anyone."*

In the **14th section** the young man releases a consideration that he apparently also had in mind in the interview, although he resisted the hypothesis of psychological problems as the root cause of his difficulties: *"But if it now turned out that the basis was really a mental problem, then I wouldn't care. For that can be better cured. A physical defect, that just stays with me. But a mental defect, you can cure that and then everything rolls back on. Then everything is back on track."* In the **15th section,** however, he reaffirms his original stance, calling these thoughts forced upon him, *"If my bodily condition is good, then I have a shield. Then I can't fall into depression at all. From the outside, I simply had an opinion imposed on me that I don't accept at all."* In the **16th section,** when asked how he felt about this conversation, the young man replies, *"It was a good conversation. I didn't feel like he didn't understand me."* In the **17th section,** he says only briefly, *"I'm just glad when someone can take away my pain. Whether the reason is mental or physical, I don't care."* In the **18th section,** he also expresses his wishes succinctly and with focus: *"I'd just like to get rid of my constant tension still."*

Summary

1. The patient repeats some of his statements from the interview, supplements them with new information, offers insights into his inner experience during the critical time of the suicide attempt, as well as during the interview, and expresses new insights into the context of his suicide attempt. In the 1st section, he says he was focused during the interview, and struggling to remember everything. He was also tense. In the 2nd section, he describes his physical symptoms with the intention of being brief. In the 3rd section, he recalled his sadness as he talked about his experiences, as well as self-doubt that he might be the culprit behind his problems. In the 4th section, he shared an important new information that he received unsatisfactory grades, and cannot finish the semester. However, his parents will not allow him to drop out of high school. In the 5th section, he commented on his emotional situation. He has a strong will, but felt hopeless and considers himself a failure. He also addresses this in the 6th section. He says his failures come from his poor physical condition, but he is able to make up for them with his strong will. In the 7th section he reveals that he received the information that he was insufficient 2–3 weeks ago. He describes his weekend outing before his suicide attempt, how he came home late and tired on Sunday, could not sleep, and did not wake up refreshed on Monday morning. His parents resented him staying in bed instead of going to school, which he took as an unkind gesture.
2. In the 8th section he expresses the thought that there is a physical fatigue and one when you have no more future. During the self-confrontation interview, he realizes that this was his problem. It would be the lack of a goal that moved him to suicide. In the 9th section, he recalls hearing a comment that he was a psychopath, which he equates with mental health problems. He then discusses his dichotomy between realizing there are mental problems that are bothering him and the fear that he must accept himself as a psychopath. He can then interpret his survival of the suicide attempt as his strength and allow himself to be accepted again. He also deals with this issue in the 10th section, stressing that having goals would protect him, that he is a lonely fighter with a strong will, and that no one understands him.
3. In the 11th section, the patient deals with the possibility of discussing his problems with someone and thinks that he is tense because he has had to struggle through his whole life. In the 12th section, he again paces the circle of his reasoning. He is hopeless, which makes him helpless, his purpose has been taken away from him and he is not understood, and if he is to be destroyed, he must be made physically weak.
4. In the 13th section, he describes his thought process during the suicide attempt. He would be torn. He would be scared, but suicide seemed like the best solution. He feels that if he had been understood, it would not have happened. In the 14th section, he seems to take something positive from the hypothesis of psychological problems. Physical problems, he says, are more difficult to treat than

psychological ones. In the 15th section he once again expresses his basic maxim: physical fitness protects him from psychological problems.

5. In the 16th section he speaks with satisfaction about the conversation in which he felt understood and in the 17th section he expresses the wish that his pain be taken away and then in the 18th section that he would like to get rid of his constant tension.

Case 12

14

14.1 Suicide Story: Yvonne, Who Can't Take the Pressure

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Yvonne lies in bed in the white sheets, her long black hair standing out well against the white pillow as she watches everything turn red under her thin wrist. She feels terrible, really miserable; again she has failed, she's no good. The inner pain she feels most of the time she has to ease with the outer pain. The razor blade is ready in the nightstand drawer, as always. But this time, just scoring her belly won't be enough. She feels such massive despair, she doesn't want to live anymore. Now the thin skin and the artery underneath must be cut. The white sheet is getting redder. Her father knocks on the door and wants to know how she is. So she quickly rolls up the sheet, hides everything under the bedspread, and bandages her hand so that her father won't notice. Despite her haste, she realizes she didn't quite cut the wrist. So she'll go on living, no one should notice, especially the father. "There, too, I fail…".

Yvonne is studying at the commercial school. She prepared very well for the first semester exam, however, she totally failed on the exam day: "I didn't pass the written exam. Can I repeat?" The next day she goes back to school – despite the bad feeling and the bandaged, aching wrist – and takes the oral exam. It goes surprisingly well. That doesn't help, though; she'd have to retake the written exam, and she definitely doesn't want to do that. Maybe she'll try to switch to high school after the holidays. Until then, she doesn't want to do anything.

Three months later, Yvonne is sitting in the psychiatric emergency ward of a hospital. She is in a very bad way. She feels only emptiness, she is of no use to anyone, life is full

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of loneliness. The father and the boyfriend advise her to get professional help. That's why she called the emergency room. She is supposed to stay 14 days as an inpatient in the crisis intervention.

She tells us that she has great problems with food, but also with her whole history, with her whole life.

It's not the first time she's been this bad, in fact she's usually very bad. She feels lonely, unable to do anything, plagued by intense inner pain. Her whole bleak past keeps playing out before her eyes. She has been here before: three months ago, after the failed semester exam. She wanted to talk, but that didn't help, also the antidepressants didn't show any effect, and so she is trying it now as an inpatient. It's all just too much for her.

She has already been in treatment as a child. At 12 years old she was admitted to the psychiatric hospital because of big problems with her mother. Those have remained, but now, in addition, there is the problem with food. Yvonne actually looks good: long dark hair, dark eyes, but she thinks she is too fat, and everything that has to do with food is very stressful for her. Either she eats nothing, or she stuffs herself with everything that is edible around her and then vomits. Everyone tells her that she is too skinny, but she doesn't see it that way.

The problem with the mother is central. She feels harassed, under pressure, like she is supposed to conform to the mother's ideas. What does the mother actually want from her? It is a back and forth, what Yvonne should do and what not, every time something different.

The parents have been separated for a long time. She lives with her father, but when she was 12 she had to stay with her mother for a year, further away. That was a terrible time. She was very much alone, locked up at home, the mother constantly holding her responsible for everything that was going wrong in the mother's life. The mother often beat her with a belt. The bloody welts were very painful. Why did the mother always get so angry, and grab a belt and hit? The face flushed red, eyes squinted shut. Yvonne asked herself every time: why, what have I done again, it hurts so much, I stayed with her because I love her, why is she so angry with me?

Yvonne is an only child, very lonely since childhood, but the time with the mother was one torment. After a year with her mother and a stay in hospital, she came to live with her father. But she wasn't much better with him. Everything caused her pressure and stress. She often felt desperate and felt this "inner pain". She didn't know how to cope with life.

Since the fifth grade she has had problems with eating and with this "inner pain". So that it does not hurt so much inside, she scores her belly with the razor blade. This happens whenever she can't take the pressure from her mother, but also other pressures. Desperation sits on her neck like a pecking raven, and with the external pain, the scratching of her belly, she alleviates this condition. She sits on the edge of the bathtub or lies in bed, absorbed, looking at her naked belly, the thin skin tightly enclosing the visible abdominal muscles, and she is driven only by the thought of relieving herself of the terrible pressure, the psychic pain, by scoring the abdominal wall. She holds up her blouse with her left hand, takes the razor blade from the drawer, places it on the left side of her abdomen, and draws it across her belly button to the right. The hair-thin line slowly turns red, a few drops form,

and the pressure softens. She is enveloped in a warmth that she savors. She closes her eyes, exhales, and lets her right arm hang. She feels a kind of release.

The mother calls her every day, wants to know how she is, what she is doing and so on, she literally besieges her and insults her. She has often asked her mother not to call so often. It makes her sick and she despairs, goes crazy. But the mother calls over and over again every day. Yvonne can't bring herself to just ignore the ringing, that would make her feel even worse. So it's a matter of enduring, gritting her teeth, choking something down quickly after the phone call, running to the toilet and throwing up everything.

The problem is that the belly cutting and disordered eating isn't solving anything. That's the reason she's here now. The father and the boyfriend advised it, but she wanted it too. She realizes herself that it can't go on like this. However, she feels insecure here: she doesn't get a single room, which is very bad for her. Nevertheless, she wants to stay here for 14 days to get some rest, to get rid of the stress. And, above all, she hopes to be left alone by her mother. She'd like to get rid of her mother. This constant back and forth. She told the mother three days ago that she wanted to go to the crisis intervention at the hospital and why. That's when the mother really snapped, calling her names and yelling at her about how everything was her fault and going on about what she and everyone else was doing wrong. She was just a bad, incompetent daughter. Yesterday she called again and said she was doing the right thing, going to crisis intervention. One time like this, the next completely different. When the mother talks about Yvonne to other people, she is the most amazing, beautiful, intelligent daughter. But when she talks to her, she only says negative things. Yvonne can't stand that. But she doesn't manage to fight back. She just wants to be left alone and be able to live her life. But she doesn't know how to do that. There's another catch. She has no positive image of herself and feels ugly. She would like to be smarter, to look different, to be beautiful. She also wants to be better at sports. She quit martial arts because she didn't have the strength. She feels she can't take anything and thinks her condition is bad. Besides martial arts, she has also run marathons and played sports more or less excessively.

Yvonne has had a boyfriend for half a year. The relationship is also not going as she would like. He demanded a lot of understanding from her in the beginning. He had a girlfriend three years ago who treated him very badly. After the breakup, he met another woman, but he realized that he still loved the previous woman very much. It was under such circumstances that Yvonne and he got together. He claimed that he had to work through the breakups first and that Yvonne had to have a lot of understanding for him. This was very difficult for Yvonne, involving much suffering and anguish. "What am I really there for him for?" She tried to find a way between his problem and her inner pain. She had hardly eaten anything and exercised a lot. When he realized how badly affected she was by his problem, he started to be more considerate of her. That is, to talk less about himself.

Actually Yvonne has it best with her father. That wasn't the case before, she couldn't talk to him at all. She was ashamed of her shortcomings, her stupidity and weakness. But that has been completely different for some time now, she can talk to him about anything now. She really likes being with him now too. But she can't say much about him. He is

quiet, good at listening. She almost feels safe with him. What Yvonne likes very much are bad "horror stories" that the boyfriend sometimes tells her. When she hears that there is much worse than her suffering, she becomes calmer.

And she also likes to help other people. She can listen and give advice when someone is feeling bad. That does not burden her. What is bad is the loneliness, the inner burden and the inner "suffering". Even when someone praises her or tells her something positive, she can't accept it. She can't believe it. She feels like a failure, a bad person who doesn't really see or have any meaning in life.

14.2 Suicide Analysis: Young Woman: "I Just Couldn't Take It Anymore. For Me Everything Was Just Finished at That Moment"

Ladislav Valach

To the question: "…why it has come to this" the young woman answers: "It's a long story". She also clarifies that in addition to her suicidal action, there are not only a number of other circumstances to consider in order to understand her action, but that one would have to trace these processes, these concerns, far back. So it is *medium-term and long-term concerns* that she sees in relation to her suicidal action. Currently, she cut her abdomen to *be able to "relieve the internal pain through it… I didn't want to die."* However, she did want to die three months ago when she "tried (then) to cut my wrist."

14.2.1 Long-Term and Medium-Term Concerns and Short-Term Actions

What is the long story that led to her suicidal action? The patient tells about her *"relationship with parents"* which preoccupied her a lot and especially about her *"relationship with her mother"* which made her unhappy. Her parents separated when she was 12 years old, she lived with her mother for a year and from then on she lived with her father. About the year with her mother, she said, *"It wasn't a very nice year. I was also home alone a lot."* The patient also spoke of her long-term desire *"to be understood",* which she very rarely gets validated. In addition, she said she wants to maintain her *"independence"* and wants to *be "accepted*" for who she is. This too she often experienced as being violated by her mother. At first she found her *"relationship with her father"* difficult, but then it improved and in the meantime she regards her father as *"one of the few people who really understand me*". The young woman then went on to talk about her *"eating disorder",* which has plagued her for several years. She does not eat, or she eats too much and then vomits. She has also been *"hurting herself"* regularly for some time, which gives her momentary relief in each case, but has also led to a life-threatening crisis. The patient was pursuing an *"educational goal."* She attended a business school, which she dropped out of, and later wanted to go to high

school. For the past six months, she has been in a *"love relationship"* in which she feels very understood. Her *"relationship with herself"* is full of conflict. She cannot accept herself and wishes to be physically and psychologically different. The patient also pursued some *"sport concerns"*. She used to do martial arts and is currently trying strength training, although she feels very weak. Finally, the long-term concern of *"living"* is also important to the patient, although this has occasionally been subordinated to other goals.

14.2.1.1 Suicide-Related Long-Term Concerns

The patient wanted to die three months ago and tried to cut her wrist. Currently, she sought help at the hospital's emergency department because her state of internal suffering, eating disorder and self-harm became very acute. She will be hospitalized at the Crisis Intervention Center for two weeks.

Besides *"survival*", the *"eating disorder*", *"finding inner freedom from pain"* and also the *"educational career"* (the patient tried to commit suicide after failed semester exams), the young woman mentions above all her long-term *"relationship with her mother"*. She is not only dissatisfied with this relationship, but actually suffers greatly from it. She feels completely helpless towards the mother. When asked if she *could*: *"…contribute something to the improvement of the relationship?"* she says *"No. I have really tried everything. I've also been talking to her with a lot of patience lately. But I just can't understand her. I tried, but just couldn't. I don't know what else to do."* This condition has been going on for a long time and has had a lasting effect on the way the patient sees and feels about herself and the world. She had become aware of it when she was 12 years old. She suffered especially from the fact that: *"my mother always (blamed) me for everything. I always had to take the fall for everything that didn't go well."* The destructive effect was further solidified by physical pain and feelings of humiliation: *"She also hit me a lot with her belt when I was a kid."* The patient even describes this as the main reason for her self-harm and suicidal actions: *"That was then also the main reason for the action."* Nevertheless, this relationship is maintained very intensively: *"She just calls me every day. I've also told her not to call me. But she still keeps doing it."* These conversations put a lot of stress on the young woman: *"They are just very tedious conversations each time. She always tells me how bad she feels."*.

It seems that the long-term concern of establishing a *"good relationship with the mother*" – she is, after all, the primary caregiver for the child – has not succeeded. The patient not only suffers from this, but subordinates to this success all her vital or existential concerns, her *"health*", her *"inner peace"* and even her *"life"*. She thinks she gained inner freedom from pain through her self-injuries, but above all she learned to punish herself because she deserved the physical pain and punishment. And when her independence project, business school, was not crowned with success, she acted as if she was unworthy of life. That this relationship overshadows everything else in her life is also expressed in her answer to the question: *"If you had a magic wand now – what would you get rid of first?"*, patient: *"My mother. This is the first thing I would get rid of"*. Breaking away from the family of origin and building up the skill of shaping encounters herself are the most urgent tasks for the young woman in the near future.

▶ **Summary**

1. The patient has been engaging in destructive activity (eating disorder, self-harm) for several years and this is integrated into a number of long-term concerns. She describes her relationship with her mother as the most distressing. This includes her relationship with parents and father.
2. Defined by her goals it is: "to be understood", "to be independent", "to be accepted". In relation to herself, she wants above all to "find inner freedom from pain", to build up her "inner peace", "relationship with herself".
3. In a constructive way she wants to achieve this through "sport", "education" and a "love relationship". If this does not succeed, she resorts to destructive and violent means such as "eating disorder" and "self-harm". The "life" or "survival" and "to be healthy" are often put to the disposition.

14.2.1.2 Suicide-Related Medium-Term Concerns and "Projects"

Among the medium-term concerns which the young woman closely links to her destructive actions, to *"hurting* herself*",* is *"coping with the regular conversations with her mother"*. The patient sees the suicide attempt three months ago as a consequence of her failed *"semester exams at business school"*. But even this is almost certainly not unrelated to her main concern and the stresses that arose from it. For in spite of good preparation, *"I really studied day and night for it,"* the patient did not pass the examinations. It would be natural to assume that her learning processes, her ability to retain and recall the material were massively disrupted by her psychological distress. We know from research that successful learning also requires a certain emotional state, which was certainly not present here. The young woman goes on to talk about her *"sporting interests*", or how it was no longer possible for her to take up *"martial arts"* because she was too debilitated by her eating disorder. If the connection of her choice of sport (martial arts) to her life struggle might seem too trivial, her weakness due to her eating disorder is certainly a part of her concerns that are closely related to the destructive actions. The patient refers to her *"relationship* with *the boyfriend,"* whom she has known for about six months, as an important part of her struggle with her mother. She especially values the conversations with him: *"I only wanted to* talk to *my boyfriend on the phone and sleep",* in which she can talk about her mother: *"I just talked to my boyfriend very often about all that. It then always occurred to me what all my mother had done wrong*". In addition, her boyfriend advised her to seek professional help, which probably proved to be a lifesaver.

▶ **Summary**

1. In the medium term, the patient is preoccupied with "coping with the regular conversations with the mother", which she did in her "relationship with the boyfriend". "I only wanted to talk to my boyfriend on the phone and sleep", "I just talked to my boyfriend very often about all that (what the mother had done wrong)".
2. She also prepared for the "semester exams at the commercial school".

14.2.1.3 Suicide-Related Actions

Project: Clinic Treatment (Patient (P), Friend (F)):

Actions Patient (P), Clinic (K), Friend (F): Registration for Eating Disorder Treatment at the Clinic

Action P: I just called the clinic once.
Joint Action Friend (F), Patient (P): This is what my friend advised me to do.
Cognition P: I have problems with my diet.
Cognition P: Then I just thought that I now once call the clinic.
Action P: So then I called here.
Cognition P: But then at that moment everything just came in one fell swoop – my whole past, my history from before.
Cognition P: It came to the point that I am sitting here with you today. I just couldn't cope with it all anymore. It became too much for me.

Joint Actions Patient (P), Clinic (K), Colleagues (Koll): Clinic Visit

Action P: Yes… I came here from time to time to talk a little and linger.
Emotion P: But then I got so bad at one point that I had to come to the emergency room. That was the case last week.
Joint Action (K), (P): Now it has also been decided that I will stay here for 14 days and recuperate.
Cognition P: Here I also have people who listen to me and who understand me.
Cognition P: I just didn't have any peace at home anymore. My whole environment was always around me.
Cognition P: It all got to be too much for me.
Cognition P: I just wanted to have a distance from everything – from my mother, from my colleagues….
Joint Action (K), (P): So it was decided that I would come here now because that was probably the best thing for me to do.
Cognition P: I have been here for a day and a night now. I must say that it has done me a lot of good. Therefore, we decided that.
Joint Action (P), colleagues (Koll): I have sometimes told my colleagues not to phone me. But nobody kept to it.

Project: Relationships with Parents:

Joint Actions Patient (P), Friend (F): Talking About the Patient's Problems

Cognition (P): I guess the (main problem) was my mother. I've had a lot of trouble with her lately.
Cognition (P): I live with my father. My mother lives in another city.
Joint Action (P), (F): I just talked to my friend a lot about all this.
Cognition (P): Then it always occurred to me what my mother had done wrong.

Joint Actions Pa tient (P), Mother (M), Father (V): Parents Separate

Cognition (P): My parents are also separated. I lived with my mother for a year at that time. That was not a very nice year. I was also home alone a lot.

Cognition (P): I was 12 years old at the time.

Joint Action (P), (M): And my mother always blamed me for everything. I always had to stand up for everything that didn't go well.

Joint Action (M), (P): She also hit me very often with her belt when I was a child.

Cognition (P): That was then also the main reason for the deed.

Actions of Mother (M), Patient (P): Shaping the Relationship

Joint Action (M), (P): Yes. She also always calls me regularly.

Joint Action (M), (P): She wants to know how I am.

Cognition (P): And that gets to me.

Joint Action (P), (M): Yes. I've also told her not to call me. But she still does it again and again.

Joint Action (M), (P): She just calls me every day.

Cognition (P): (That bothers me).

Cognition (P): Exactly that, yes. They are simply very tedious conversations in each case.

Joint Action (M), (P): She always tells how bad she would feel.

Cognition P: (So she only calls because she expects help from me) Yes. That will probably be the case.

Project; Education:

Actions Patient (P): Commercial School Exams

Cognition P: Yes. I put too much pressure on myself.

Actions P: I'm doing business school – or rather I did.

Actions P: I had semester exams.

Actions P: I really studied day and night for it. But still the exams went down the drain.

Cognition P: That was a big setback for me.

Actions Patient (P): Change of School

Cognition P: Yes, I was able to relieve the stress.

Actions P: But I am not attending business school now either. I have decided that I will then attend grammar school after the summer holidays.

Actions P: Until then, I'm on vacation.

Suicide-Related Project Patient (P): Eating Disorder

Cognition P: That (problems) happened a long time ago.

Cognition P: But it didn't break out like a disease until the winter. It only really became clear to me at that time.

Cognition P: I had problems with eating since the fifth grade.

Cognition P: But my weight was always going up and down a little bit for a long time.
Cognition P: But for some time now, the weight has only been going down and not up.
Action P: That's why I then also phoned the hospital.
Cognition P: It's just not a state like that. I knew that this was no longer good and that something had to be done about it.
Cognition P: It's still weird.
Action P: I called nutritional counseling here.
Cognition P: But now I'm here because I can't cope with my problems. That's a strange situation. I have to get used to it first.
Actions P: It just alternated. Either I didn't eat anything or I threw up everything I ate right away. That simply formed a cycle.
Cognition P: It was always like that before.
Cognition P: But in the winter, everything just came together. Everything just came together.
Cognition P: That was more of a negative experience.

Suicide-Related Actions Patient (P): the Last Crisis; Hospital Admission
Actions P: It was so that I always stayed at home.
Actions P-: I just didn't do anything anymore.
Actions P-: I used to play the guitar. Now I no longer did that.
Actions P-: I also stopped doing martial arts.
Actions P-: I didn't do anything anymore.
Actions P: All I did was go to school.
Actions P: After school, I always went straight home and holed up in bed.
Emotion P: I also cried a lot.
Actions P: I cut myself off from life.
Cognition P: And then there came a time when I realized that I couldn't handle the pain inside.
Cognition P: I hadn't talked to anyone about any of this.
Cognition P: I tried to deal with it, to find a way. But that didn't work out.
Actions P: I then realized that I could deal with it if I caused myself pain.
Cognition P: It was just about being able to relieve the inner pain through that. It was just about that. I didn't want to die.
Actions P: I cut myself on the abdominal wall with a razor blade.
Cognition P: Up until about two to three weeks ago, I was in a bad way.
Cognition P: Not in the last three weeks. The tornado has subsided somewhat.
Emotion P: But before that, it was already the case that this feeling became stronger and stronger.
Cognition P: But things are better now. It was always a back and forth.
Cognition P: But now lately I've been getting better day by day.
Cognition P: Today I am actually fine now.
Cognition P: But I don't feel so comfortable here (in the clinic).

Cognition P: (I am here) Since this afternoon.
Cognition P: I'm not feeling so well. I have no idea how I'm going to do this for 14 days. But it will work out somehow.
Cognition P: I decided this on my own (that I would be an inpatient here).
Joint Action P, father (V), friend (F): But I talked to my friend and my father beforehand.
Joint Action P, father (V), friend (F): We then agreed and said that I should do it now.
Cognition P: From that point of view, I also have a good backing from that side.

Actions of Crisis (P):
Cognition P: I think that was also related to the medication I was on. I had an antidepressant. This just didn't have any effect on me.
Cognition P: That was already very depressing for me.
Cognition P: There was also the whole thing with my mother.
Cognition P: On top of that, I was also unhappy with myself. I simply noticed that my body no longer had any strength (on the athletic level).
Action P: I quit martial arts a long time ago.
Actions P: I have now started strength training again.
Action P: I've had to let this go lately, though, because it wasn't working.
Emotion P: (I'm sick of it all).
Cognition P: I didn't want to do anything more at the moment.
Cognition P: I had no interests at all anymore.
Actions P, Friend (F): The only other thing I did was to talk to the friend on the phone.
Actions P: I didn't want to go out, I didn't want to eat… I just didn't want anything.
Actions P, Friend (F): All I wanted to do was talk to my boyfriend on the phone and sleep. That was all I wanted.
Cognition P: That helped me very firmly.

Suicidal Ideation Patient (P):
Cognition P: Yes, (I also had the thought of doing something to myself when I was feeling so bad). That is already the case.
Action P-: But… I didn't do it after all.
Cognition P: I was already imagining what it must be like to jump off a bridge. Cognition P: I think everyone thinks about that at one time or another.
Action P-: But I left it at that.

Suicidal Action Patient (P):
Action P: Yes, yes. (I have already attempted suicide). But that was some time ago now.
Cognition P: That was about three months ago.
Cognition P: The trigger was my semester exams… These were the trigger for this act.
Actions P: I really studied day and night for this exam.

Cognition P: It was still the Christmas season, too.
Action P-: I didn't even really take a vacation.
Actions P: I was just always learning all the time.
Actions P: And then the exams went down the drain. Every single subject was unsatisfactory.
Cognition P: This was just too much for me.
Cognition P: I just really couldn't take it anymore.
Action P: Yes… I was alone in bed that night.
Joint Action P, F: That evening I also spoke to my boyfriend on the phone.
Cognition P: I just couldn't take it anymore.
Cognition P: For me, everything was just ready at that moment.
Action P: I then attempted to slash my wrist.
Cognition P: But that didn't work out so well.
Cognition P: There was a lot of bleeding, but the vein was not severed.

After the Suicide Action Patient (P):
Cognition P: I then had my last semester exam the next day.
Action P: To my amazement, I wrote a relatively good exam.
Pain P: The wrist did hurt.
Cognition P: But I knew it was my own fault.
Cognition P: That's why I was willing to suffer.
Action P: Yes, I badaged this myself at home.
Action P: I did that all by myself.
Action P: I remember I had to change the sheets. There was just blood all over everything. I did all that that very night.
Cognition P: It's just hard… I've been thinking a lot lately about how and why it got to this point.
Pain P: When I remember it back, it hurts me – the cutting hurts me even after the fact.
Cognition P: I think it was just bound to happen at that point.

Present, Hospitalization, Patient (P):
Cognition P: No, (it didn't change anything for me), that's actually not the case.
Cognition P: The cut itself didn't change anything in my life. But everything else has changed. I think very differently. I learned to think positively….
Cognition P: Yes, that (therapy) is certainly an important factor in this process.
Cognition P: I have no expectations (of the hospital stay).
Cognition P: But I just hope that when I come out of the clinic after 14 days that I will be … – not that I will be a different person. I don't expect that. But that maybe I'll be calmer.
Cognition P: I just want to be a little more mature, be able to see everything a little differently. Those are the things I expect.

Cognition P: But I don't expect all this from the clinic. I expect this from myself.
Cognition P: The hospital stay might help me with that, that might already be the case. You just have to let it happen.
Cognition P: I'm not so convinced about the whole thing.
Cognition P: But I just know now that I have to go through it.
Cognition P: Luckily I also have a good environment (father, friend, colleagues) that looks to me. It will work out somehow….

Relationship with Mother (Patient (P), Mother (M)):
Cognition P: (Now if I had a magic wand – I'd get my mother out of the world first) This one I'd get out of the world first.
Cognition P: Yes, (that weighs heavily on me). You can already say that.
Cognition P: It's just related to her nature.
Joint Action P, M: I told her I had to go to the clinic.
Joint Action P, M: I explained to her what it was and why I was going there. But she yelled at me on the phone and completely freaked out. Everyone was just to blame for everything – only she wasn't to blame for anything.
Joint Action M, P: Two days later she called me again and told me that I was doing very well, that the clinic was the best thing for me and that she could not have done better.
Cognition P: This constant back and forth just wears me out. It's all really tiring.
Cognition P: She (mother) should now just leave me alone for a bit.
Cognition P: I just need some rest. She should let me live the way I want for once.
Cognition P: She should accept my decisions, even if she thinks differently. She should just accept that I have my own life.
Cognition P: Otherwise I wouldn't change anything.
Cognition P: No, I don't feel like I could contribute to the betterment of the relationship either.
Actions P: I have really tried everything.
Actions P, M: I've also been talking to her with a lot of patience lately.
Cognition P: But I just can't understand them.
Actions P: I tried, but just couldn't do it. I don't know what else to do.
Cognition P: I also struggle with being the perfect daughter for her.
Actions M: When she meets someone, it's always I would do such and such, I would only eat such and such, etc.
Cognition P: That's all well and good when she talks about me like that. But I'm not that super intelligent.
Cognition P: I just struggle with her making me a different person than I really am.

Accepting Oneself Patient (P):
Cognition P: I want to be very different from who I am now. But I think everyone wants to be different than they really are. I would like to be more intelligent, look different… I don't know. But everybody has his own ideas about that.

Relationship with Boyfriend (F), Patient (P):

Cognition P: The relationship with my boyfriend and his understanding helps me a lot. These two things help me a lot.
Cognition P: I've only been with him for six months.
Joint Actions P, F: We have now just gone through a right crisis together.
Actions F: Three years ago he had a girlfriend who treated him badly.
Actions F: Then he got into another relationship.
Cognition F: But in this one he just realized he didn't love this woman.
Action F: And then he got together with me.
Cognition F: Then he realized he still had to process his first relationship.
Cognition P: It just requires a lot of patience on my part.
Actions P: I can also give him time.
Cognition P: But it wasn't easy for me. I had to find a way that was bearable for me.
Actions P: Then out of that came different things. I stopped eating, I did a lot of sport…
Actions F: when he realized how hard it was for me, he tried to make it more bearable for me.
Cognition F: He just realized what he had done to me.
Cognition P: From that point on, it got better. It is also bearable at the moment.

Independence; Patient (P):

Cognition P. It's just scary that you can't manage on your own anymore, that you have to rely on help.
Cognition P: I am a person who always wants to get everything going on my own.
Cognition P: And now here I have to get help.
Cognition P: I'm trying hard at this, too.
Cognition P: But I can't quite get my head around it. I have trouble with it. I can already tell.
Cognition P: I actually think it's a pity that every person lives for himself and has no contact with the other fellow human beings.
Cognition P: But I just notice that with me, that I want to master everything on my own.
Cognition P: That's already just not the point. I have to get help now.
Cognition P: That addiction feeling is just weird for me. I don't like being dependent.
Cognition P: I like to help my fellow human beings.
Actions P: I always listened and tried to give advice.
Actions P, others: That was also the case when I was feeling bad. It's still funny… It was very often older people who came to me.
Cognition P: Then I always tried to imagine how I would react in their situation and at their age.
Actions P: Based on these considerations, I then gave advice to these people.

Understood; Patient (P):

Cognition P: All this was also an important experience for me.

Actions other, P: When people listened to me, they also always tried to put themselves in my place. But they almost never succeeded.
Cognition P: I just realized that there are very few people who can understand me. I definitely experienced it that way.
Cognition P: That was already the case (I then also felt left alone when I realized that no one could understand me).
Action P-: But I didn't try either… I couldn't talk to my father at all in the beginning.
Joint Actions P, Father (V): But now I could tell him everything and tell him how I experienced everything. Lately I talked a lot with my father.
Cognition P: I also realized that he was one of the few people who really understood me. That did me a lot of good.

Crisis at Twelve; Patient (P):
Actions P: I've had to overcome a low like that before too.
Cognition P: But I don't think I really realized it at the time. I just repressed it at that time.
Cognition P: That was when I was 11 or 12.

Present
Cognition P: But it is now the first time that it showed such bad effects that I had to come here.
Joint Action F, P: My friend simply said that it would be better for everyone if I went here now.
Cognition P: And right now I'm doing really well too. I also see a bit of a future again. That is already very important for me. ◄

► **Summary**

1. The patient describes actions and action-relevant thoughts she undertook as part of her mid-term projects, which she sees as closely related to her suicide attempt and her self-harming actions. She talks about her clinic treatment, how she signed up for treatment for her eating disorder at the clinic, her stay at the clinic, and then goes on to talk about her actions in her relationship with her parents. She also says that her conversations with her boyfriend were very important.
2. She tells how her parents separated when she was 12 years old, talks about her education, her failed exams and her aspiration to change schools.
3. The patient talks about her eating disorder, her last crises, the hospital admission, her suicidal thoughts, her suicidal action and the time after the suicidal action.
4. Then, when she talks about her presence, she comes back to her relationship with Mother, which weighs heavily on her, as well as her own concerns such as "accepting herself," "being independent," "being understood."

14.2.2 Problems of Action Organization

The young woman is currently in inpatient treatment to deal with her eating disorder and self-harm. She attempted suicide three months ago after failing her semester exams. She sees this suicidal action, her eating disorder, and her self-injuries in a larger context and also closely linked. How is it that she abandons her all-encompassing goals of life preservation and pain avoidance in order to achieve other goals, usually secondary to these concerns? From her narrative, it appears that by the time she failed her semester exams and wanted to commit suicide, she was already in a period of crisis that severely affected her actions and thereby also upset her order in the hierarchy of goals. Thus, she experienced giving up life as justified as a consequence of the failed test. Of course, this was not done in a logical conclusion, but by realizing that she could do no more. She saw the studies, the exams, as the last opportunity to contribute to her life, after she had given up, or had to give up, her sovereignty over all other areas. This way of ordering one's own goals in this way presents a problem of action. The close link between successful exams and her life was embedded in the young woman's long-term concern in which she could not successfully engage in her relationship with her parents and especially with her mother. She sacrificed the goal of freedom from pain for the concern of improving her relationship with mother. Again, this did not occur as an explicit means-ends relationship, but rather the patient describes this as, "she had developed a tension in her encounters with her mother that could be mitigated in the short term by cutting at her abdominal skin." In the medium and longer term, the patient tried to regulate these difficulties by manipulating her food intake. She sometimes ate very little and then ate too much, which she corrected with vomiting. All these existential goals, such as maintaining life, avoiding pain, eating healthily, feeling well, the young woman gave up for other goals, which also became existential goals, such as sorting out her relationship with her mother or passing her school exams. She lets it be known that other goals also remained unattained, such as feeling understood and accepted, which she then tried to correct by "rejecting herself," "shingling," "treating her body harshly." Already from these remarks it is evident that not only the action organization but also the action monitoring processes were disorganized, as suggested by the jumble of planning thoughts, emotions and pains.

▶ **Summary**

1. In a longer crisis phase, the patient confused her current state of mind after failed exams (I could no longer) with a tiredness of life. In addition, she saw her exams as the last opportunity to be involved in her life, and linked exam success with her life. She also sacrificed the goal of freedom from pain to the concern of coping with the consequences of contact with her mother.
2. She describes how in an action regulation (to relieve a tension in the short term by cutting at the abdominal skin) she gave up other long-term and higher goals, such as preserving health and life. Moreover, she also tried to regulate this by manipulating food intake (eating disorder). In addition to the problems in the hierarchy of goals, the confusion of action-regulatory processes with goal-setting steering processes of action is also evident.

14.2.3 Consciously Prepared or Spontaneously Undertaken?

From the patient's narrative it is evident that she frames her approach to dying or her intention to die differently, using the deliberate and the spontaneous in a different way. In her suicide attempt three months ago, after a failed exam at school, she felt she could take no more and attempted to take her own life. Although she had been on a destructive path for years (eating disorder, self-harm), the thought of killing herself only crossed her mind in the short term and she knew what she was doing. The shift from a life-oriented concern to a destructive one was deliberate and goal-directed, as was the slitting of the wrists. In other cases where she cuts herself to end internal pressure this is the primary goal and dying is only a side effect. So she doesn't want to end her life, she just wants to end the pressure. This is a kind of dying by self-regulation, whereas her suicide attempt was goal-directed dying. Perhaps dying can be described as an accepted consequence of self-regulation, a bottom-up conversion from a life-affirming concern to a destructive concern.

▶ **Summary** The patient reported two types of suicide attempts. In one case she wanted to die when she failed her exams, and in other cases she would accept dying as an unintended consequence of her self-harm.

14.2.4 Problems of the Action Monitoring Processes

The idea that "I did not pass the semester exams and therefore have to leave this life" obviously does not adequately reflect the real situation of a young person. Likewise, the impossibility to experience the emotional condition as an emotional condition and therefore to concretize this in pain, as is often the case with self-injuries, shows a disorganization of the self-monitoring process. Also, conversely, to reduce emotional processes through pain rather than by attending to cognitive-emotional processes points to a problematic nature of the self-monitoring and action-monitoring systems. In this context, it can also be understood that, just as certain emotions cannot be admitted in their quality but only in their intense effect and can be influenced by pain experience, certain thoughts can also be so threatening that they are not admitted and are realized in other self-destructive intentions. Likewise, the young woman's unsatisfactory encounters with her mother, whose experience she attempts to process by experimenting with food intake, suggest a failure of the self and action monitoring systems. Of course, this can be explained by the stage of development of these systems, for the problems in the relationship with mother go back a long way, even though the suicidal action occurred only in early adulthood.

▶ **Summary** As the patient attempts to regulate her emotional life through pain, her problems of action monitoring become apparent. Moreover, her present experience of emotions in the conversations with her mother is replaced with memories of emotions from the time when she was helpless and her mother also punished her

painfully. Thus, monitoring through emotions and pain is especially problematic. Her monitoring through consciousness may be affected in that she is unable to come up with a problem-solving and coping strategy appropriate to her age.

14.2.5 Problems of Action Energization

One of the young woman's statements about her state of mind during the suicidal crisis concerned her action energetics and their problems. She not only meant that she could no longer, but also stated some time before that she no longer had any strength, could no longer practice her martial arts, and could no longer do anything in everyday life. She didn't mean that she couldn't see a purpose in life anymore, but that she couldn't anymore, it was too much for her: *"It was just too much for me. I just really couldn't take any more"*. Again, this shows that the patient was not able to address her everyday problems in the area of problem solving, nor in her emotional experience, but they came through completely as a lack of energy. They were not experienced in their cognitive-emotional qualities, but were perceived as an inability to provide the energy needed to act.

▶ **Summary**

1. The energizing issue seems very relevant to the destructive actions in the patient's crisis (I just really couldn't take it anymore).
2. She also felt very weakened in her daily life (gave up martial arts couldn't do anything anymore).

14.2.6 Suicide and Interactive and Joint Action

As the young woman recounts her suicidal crisis and self-harming actions, she embeds them in some relationships with other people. She did attempt to slash her wrist after being unsuccessful on the semester exam, but this was only the latest in a series of stresses. While the young woman's studying for and even passing exams were single actions, the patient described her relationship with mother as the main problem in her life. The patient described the year she spent with her mother as a 12 year old as very unhappy. Later, when she lived with her father, her mother called her daily and burdened the patient with her own problems, which overwhelmed the young girl. She also experienced the relationship with her father as difficult at first. At present, however, her father was the only person who really understood her. It was the relationship with her mother that she associated with her eating disorder, her self-harming actions, as well as her suicide attempt after the failed exams. Her relationship with her boyfriend seems to play a conflicting role. They have known each other for six months. He brought some unprocessed relationship crises into the new relationship with the patient. The young woman felt she could help him, understand that, and give him the space he needed. However, she had to deal with this burden

herself, which she did in her eating disorder. When he realized what he was doing to her, much changed and she experienced his attention as helpful. Perhaps this burden was also what she was experiencing with her mother – and analogously, she wished the mother would also recognize all that she had done to the patient. The patient was able to confide in her friend at length about her suffering with her mother, and her telephone conversations revolved around such experiences. While the patient thinks this helped her, one might also suspect that it kept her awake from this pain. She spoke to him on the phone immediately before her suicide attempt and the conversation did not deter her from her plan. Later, the boyfriend recommended that she enter the hospital, which may have saved her life.

▶ **Summary**

1. The patient describes her relationship with mother as the main problem of her life.
2. Her relationship with her father was difficult at first, but at present she feels that he understands her very well.
3. Her relationship with her boyfriend was a heavy burden for her in the beginning, but now she experiences his attention as helpful.

14.2.7 The Young Woman's Conversation with the Psychiatrist

The young psychiatrist takes an active part in the patient's story and tries to find out more about many things that seemed unclear to her at first. In the **first joint action** she defines the joint task to clarify "…why it has come so far that you are now here with us (in the clinic)?". The patient accepts this task and tells about her problems, the entry process and her wishes. When she was then asked about the main problem in her life, in the **second joint action** she describes her difficult relationship with her mother. What she did wrong, how her mother hit her with her belt, how she always blamed her for everything, how the patient spent an unhappy year with her when she was 12 until she moved in with her father, and how her mother called her every day telling her how bad she was. The psychiatrist introduces the **third joint action** by asking if she has been under pressure from other sources lately. The patient briefly talks about her school or exam problems and her change of school. The two then, in the **fourth joint action,** clarify the antecedents of the patient's last crisis of a few weeks. The patient describes how she had eating problems as early as the fifth grade and how they came to a head so that she signed up for clinic treatment a few weeks ago. At the psychiatrist's request, the two women devote the **fifth joint action** to the patient's change since the last crisis about a month ago. The patient expresses her discomfort at not having a single room in the clinic. In **sixth joint action,** the patient and the psychiatrist elaborate on the details of the patient's "I've been miserable." She tells how she could not do anything anymore and could not eat – only talk to her boyfriend on the phone and sleep, how she could not deal with the inner pain in any other way than cutting herself, how she was dissatisfied with herself and her "…body had no strength at all anymore". The young woman describes her suicidal action three months ago as well as her

suicidal thoughts in the **seventh joint action.** The psychiatrist helps to develop this suicide narrative: "Did you also have the thought of doing something to yourself when you were feeling so bad?" "Did you have any specific thoughts about what it would be like? Or was it more of a desire to just not have to get up one morning?" "So you've never attempted suicide before?" "How long ago was that?" "Can you tell me what had triggered that?". And as the patient pauses, "I just really couldn't take it anymore." The psychiatrist asks, "And then…?" to which the patient describes how she tried to slash her wrist. The two women clarify the time immediately after the suicide attempt in the **eighth joint action.** They discuss whether anything has changed since then in the **ninth joint action.** The patient expects herself to become more mature and calm in treatment. The **tenth joint action** develops when the psychiatrist asks about the patient's main problem. The patient says that her mother is the biggest burden on her, that she is completely helpless and that she cannot improve the relationship because she has already tried everything. The mother should accept her as she really is. This leads the psychiatrist to the question: "Do you accept yourself as you are?", which the two women discuss very briefly in the **11th joint action,** because the patient says "I'd rather not say that now. I want to be very different from who I am now." and remains silent. The psychiatrist tries to liven up the conversation with the **12th joint action** and asks about the pain the patient described and what can relieve this pain. The patient says the boyfriend helps her a lot and they try to explore the patient's relationship with her boyfriend in more detail. The patient states with some surprise that she ended up in the clinic anyway. For her this is: "…frightening that (she) can't manage on her own…" and they discuss the issues of "feeling dependent" and being independent in the **13th joint action**. From this they develop the theme of how the patient relates to other people in the **14th joint action.** For her, "being able to understand" is the most important thing, and she refers to her father as one of the few people who really understand her. In the **15th joint action** they discuss the patient's problem insights. She says that she did not have them when she was 12, in the last crisis she became aware of them and now she "…sees a bit of a future again". The two women conclude the conversation in the **16th joint action**.

▶ **Summary**

1. In the first joint action the psychiatrist and the patient agree on the joint task, the patient describes her problems and in the second joint action she talks about her difficult relationship with her mother. In the third joint action she also talks about her school problems.
2. In the fourth joint action, the patient describes the history of her last crisis when she presented for clinic treatment and how she has been struggling with her eating disorder for several years. In the fifth joint action they talk about the changes they have achieved.
3. In the sixth joint action the patient describes her inner experience of the crises and her destructive actions. She describes the suicidal action in the seventh joint action.

4. In the eighth joint action they talk about the time after the suicide attempt and the patient's expectations from the treatment (ninth joint action). In the tenth joint action the patient expresses how the mother should change and in the 11th joint action she tells how she would like to change.
5. In the 12th joint action they talk about the patient's pain and the feelings and thoughts associated with it and in the 13th joint action they discuss the patient's way of relating to others. In the 14th joint action the patient expresses how important it is to her to understand and be understood and in the 15th joint action she reveals how her understanding of her problems has developed over the years.

14.2.8 The Self-Confrontation Interview

In the **first section,** the young woman comments on how she feels about watching herself in the video. She says, "It's very interesting to watch how you look on the tape." When asked if it was as bad as she expected, she briefly said, "Yes." She immediately devotes herself to observing her interlocutor. She also formulates a very important thought that we also hold in our reflections, "I also think that it would still be important to know the patient's history. One should simply sit down with the patient for a day or half a day and listen to his life story. I guess that's wishful thinking. But I do think that one should be a little bit more responsive to the patient."

Already in the **second section of** the self-confrontation, the young woman gains an important self-knowledge from her observation: "It was still interesting to watch me picking at my clothes all the time. I didn't notice that at all. I wasn't even aware of that at the time. It's very interesting to look at what you're doing when you're talking about certain things." She was referring to her mother.

The patient also complained in the first sections of the self-confrontation that the doctor was very neutral, which did not allow the patient to come out of herself. She felt that the doctor was too shy, which the patient herself was as well. But now, in the **third section** she remarks, "It's a very interesting passage. When I started talking about (my crisis a few weeks ago), she moved with it. You can just tell she joined in the conversation too."

In the **fourth section** of the self-confrontation, the patient is also aware of the connection between her narrative and her non-verbal behavior: "It's funny when you hear yourself telling all this on tape. Then there were the reactions of me again… For example, when I told where I had cut myself, I made a hand movement – a protective movement or something like that… And there was still just at the end of the sequence. I don't remember what I just told at that point. But that's when I did something with my hair. That's funny. In my mind, that just represents a red herring."

In the **fifth section,** the young woman explains that she thought about whether she should talk about her suicide attempt: "I thought about whether it had been right for me to have said it… I mean the last thing I said – the suicide."

In the **sixth section,** the patient also devotes attention to her interlocutor, "I thought she looked very shocked when we talked about the suicide. She was just very pale in that section." The patient finds her interlocutor distant again in the **seventh section,** "You can tell that there's a certain distance being established from both sides again. I feel that way." Moreover, she emphasizes that she not only does not want any contact with her mother, but that she also: "…does not need any understanding from her." She also acknowledges the relevant questions, "Just that blatant is your desire?" Patient: "Yes, just that blatant." Question: "so you want her erased?" Patient: "Yes." After the most difficult facts have been addressed or said, the young woman finds the conversation in the **eighth section** more relaxed, but also perhaps less relevant to her: "From that point on, it was just like talking in a restaurant." After viewing the **ninth section,** the patient adds a piece of information about how she came to be with her father at that time when she was 12 from her mother, which played out more dramatically than one would think from the conversation, "My mother put me out on the street… She just wasn't okay with me being with my father sometimes. That's when she told me… No, she didn't tell me anything. She just took my stuff and threw it out the window. So that's when I went to my father's house." In the **tenth and final section,** the young woman adds no new information or observations.

► **Summary**

1. The patient observes herself (second section) and her interlocutor (third section) very closely and discovers many things that she had not noticed during the conversation. She finds it especially important that she was able to tell her life story (first section). In the fourth section she relates her statements to her manifest actions.
2. In the fifth section, she talks about her inhibition to talk about her suicide and notes her interlocutor's horror in the sixth section.
3. In the seventh section she feels that her interlocutor does not appreciate her attitude towards her mother and in the eighth section she notices a cooling of the relationship to a relaxed but an arbitrary conversation. She adds that the events leading up to the move to the father were much more violent than she portrayed in the conversation with the psychiatrist.

Part III

Conclusion

Suicide Prevention

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In this book, we have met people who were so desperate that they were willing to give up the most important thing – their lives – in order to escape other subjectively perceived threats and problems. This has also shaken us. From this our concern has arisen: we want to dare to formulate how we can meet a suicidal person, or a person after a suicide attempt, and help them to act in a life-oriented way.

In the introductory chapter, we formulated some notions of how a suicide and suicide attempt can be understood. With these conceptions we were able to describe the suicidal events of the respective persons in a certain order and to identify a number of problems of action. These conceptions point to consequences for the encounter and treatment of suicidal people. It is, first of all, the conception of suicide as a goal-directed action. Something did not happen to the person, but the persons did it themselves, for whatever reason and with whatever clarity of consciousness. This is important to establish for further treatment of the suicidal person, because the goal of treatment is to develop other options for action and to have them ready for critical moments. The most important thing, however, is to win the person in her goal orientation, her intentionality to a joint project of securing her life and not to meet a patient in treatment who is acquiescent and passive. Moreover, after a suicide attempt, people describe how other medium-term and long-term processes and concerns are part of their suicidal action. The issue here is not whether these are the cause of the suicidal action, but rather it is first of all just that the suicidal action was conducted within these concerns. Patients are convinced that we cannot understand their suicidal action unless we know how it is embedded in other broad processes and concerns. In order to provide sufficient space for this account, it is important to support the person after a suicide attempt to articulate their story and their narrative of these processes. However, it is not only about telling, formulating, becoming aware of and re-experiencing the feelings behind each fact, but also about being heard. It became repeatedly clear in people's

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narratives after a suicide attempt that they wanted to be heard, to receive attention, affection, recognition and, finally, to be taken seriously. For some, this even became the decisive reason for their suicidal action. Another suicide-preventive function of talking about one's own suicidal action lies in the reliving of the suicidal process that was formulated and expressed. Many of us can recall our surprise at how we were moved by the enunciation of certain memories. Thus, patients can examine the whole suicide process after such difficult moments in conversation and let the speaking out of difficult facts work (on them).

This purpose is (also) served by the video-assisted self-confrontation interview, which helps the narrator to formulate the thoughts, feelings and sensations that did not come up or were not addressed in the conversation. Moreover, this repeated attention to the story, the narrative, and the suicidal person's storytelling helps to underscore the importance of the patients and their actions. From their narratives, we know that acting together with others, relationships, bonds, and long-term togetherness are the narrow framework of any suicidal action or attempt. It is therefore important to offer suicidal people a joint life-oriented "project". Support for continuing to live without suicide will not, however, be exhausted in a meeting, a conversation about the suicide action and its antecedents, but it must include this medium- and long-term togetherness in whatever form for a longer period of time. This is the core of any psychotherapy.

In the analysis of the individual cases, we showed which problems of action the suicide actions and suicide attempts contain, which must be considered in a suicide prevention intervention. The problems of action organization include problems of hierarchy of long-term and medium-term concerns, projects and goals. These contexts of thought and action are often accessible in conversation or can be made accessible if not consciously. There are many psychotherapy and counselling techniques and methods that deal with such processes and with which a change can be worked out along this path. The problems of the order of action in the hierarchy of steering, control and regulation can also be discussed with the suicidal person, but beyond that they must be patiently practiced. This is because regulation processes occur, proceed, and usually operate almost automatically. Action regulation may feel very conscious, but if it takes place in terms of conflicting project goals, this is of little help. We know the insight of feeling like we are in similar situations over and over again. We also need to address the processes that disrupt this hierarchy of action. We know that many good medium- and long-term intentions do not materialize in a short-term action, because actions do not always follow a pre-planning. This is evidenced by habits, conflicts, and many of the problems addressed in suicidal action. Sometimes problem-solving tasks, which are rarely used in psychotherapy (e.g., Tower of Hanoi), show how people behave in problem-solving and especially what they do, think, and feel when the task overwhelms them. There, too, we can trace the problems of the order of action. Therapeutically, the goal is usually not to learn a rationally better problem-solving strategy, but to restore the optimal order of action. We discussed the processes of top-down and bottom-up steering of the shift from life-affirming to suicidal projects. It is primarily the bottom-up processes that suicidal people say are automatic and therefore

need to be addressed with the appropriate techniques of behavior change, impulse control, regulation, and modification of automatic responses.

A special chapter is the treatment of the problems with the processes of action monitoring. These problems also constitute the subject of treatment techniques in many other psychotherapy approaches and methods. Dissociative states, problems of emotional processes, and pain experience provide a broad problem base for psychotherapy. All of these processes are also encountered in suicidal people and need to be resolved. Mindfulness exercises for each experience offer the simplest approach. Dissociative states often show up as clear indicators of suicidality. Our special attention is required for traumatic experiences that show up as emotional threat, which then very often results in suicidal action. Many exercises to not only perceive the emotional experience, as aimed at in the mindfulness exercises, but also to express it in a differentiated way and not to relegate it to the experience of pain can be used here. Post-traumatic stress disorder treatment is used not only to address past traumatic experiences, but also suicidal goals (van Bentum et al., 2017).

Attention must also be paid to the energizing processes, although these are very often treated in connection with the focus on the emotional experience. The methods of treatment of the depressive states are very well suited for these problems.

Interactive and joint action is taken into account in several ways. On the one hand, suicide prevention takes place in a joint project with the therapists. Secondly, the way in which the suicidal person relates must be worked through. It is therefore important that suicide prevention treatment is not seen as a set of different techniques, but is framed as a joint concern and enterprise between the suicidal person and the psychotherapist. Finally, any relevant attachment and relational trauma must also be resolved. We pointed out that learning to recognize the difference between an emotional memory and a situation-appropriate mirroring is especially important.

Subsequently, the actions, action steps, mental processes and regulatory processes in the context of the threatening situation are to be elaborated as strategies that enable the continuation of life-affirming projects. In the suicide literature, these are often discussed as a "safety net". They need to be practiced. A good approach is for patients to do this using the videotaped narrative of the suicide event. They can name their new alternative course of action at the point where another course of action would lead to a life-affirming course of action. The notion of implementation intentions corresponds well to this process. With video support, the implementation intention becomes more specific and therefore more successful.

Finally, the project character of the joint life-affirming concern of the patients and the therapists must be taken into account in a suitable form over several months. The contacts can be maintained in repeated meetings, in telephone or written contacts. Even regular written "reminders" can have a suicide-preventing effect.

The ASSIP intervention (Gysin-Maillart & Michel, 2013) contains many of these ingredients, albeit in an abbreviated form. It is a brief intervention with people after a suicide attempt who are treated in a general hospital ward. In a narrative interview, patients are asked to tell their suicide attempt stories in detail. The psychotherapist helps them to

keep the flow of the story going and does not disturb the patients with questions about details that might be relevant for the hospital documentation but that the patients themselves do not see as part of their story. Patients are not challenged in what they say or devalued as a person; rather, they are supported and valorized. As their account is accepted, they are also not asked for explanations or justifications. Patients are encouraged to let their story unfold. Their emerging feelings are acknowledged and fed back. The psychotherapist must also be able to answer the question of how the patient wants to be seen and help the patient to be seen in terms of her goals. There are many helpful papers on how to create an open, encouraging and appreciative interview.

This conversation is recorded and then shown to the patients in short segments (video self-confrontation interview). Patients are asked to verbalize thoughts, feelings, and sensations at the time of the interview. In addition, any new information or comment is acknowledged. Patients should have enough time to let the video recording work without feeling pressured to justify themselves. During the viewing of the video, many things happen. Patients are confronted with their suicide history in a new situation. During the confrontation, they are less pressured by their strong feelings about the suicide situation than they were during the interview, and they are no longer under their usually self-imposed pressure to present their story in a way that does not provoke rejection from the other person. Through their observing, patients can also take on the perspective of others, even if only partially, and view themselves through the eyes of an observer. They hear their suicide story told by a person on the video recording. They also see the joint action of the psychotherapist and the patient in this narrated story. By verbalizing thoughts and feelings that were not expressed in conversation, the patients also better recognize the inner connections of their suicidal action. Finally, the effect is further enhanced by the fact that actions and thoughts to which we turn our attention are revised, and usually in terms of our overarching values and goals. Let us keep in mind that at the time of the interview and the video self-confrontation interview, none of the patients wanted to die, as was still the case in the suicide situation. Therefore, the overarching goals and values are already life-affirming at this moment. In addition, the detailed attention to the patients, to everything they said, and the accurate documentation of their history is a great appreciation. This leads to a change in the actions and thinking of the suicidal patients and certainly contributes decisively to the suicide-preventive effect of the ASSIP procedure.

After the video self-confrontation, it is possible to move on to the planning of life-saving measures: what alternative courses of action do patients see in problem situations, and not only when they resort to medication or a weapon? These can then be pinpointed using the video recordings of the conversation. This turns them into implementation intentions that have much more chance of coming to fruition than an unspecified intention. It is important to record these tactics and strategies in writing so that patients have them readily available when they need them.

Thereafter, the psychotherapist should regularly check in with the patient in the agreed manner to confirm their participation in the joint project of securing their life. This can be

done by a letter, a message or a phone call. The aim of this is to remind the patient of the agreed common intention to work on the life-support project.

It is to be hoped for the action analysis of the suicide procedure described here and the suicide prevention procedure ASSIP briefly outlined that they will be seen as a helpful alternative to the usual understanding and treatment of suicidal people. It is an alternative to the incapacitation of patients on the one hand and the fatalism of a "you can't stop people if they really want to die" on the other.

Summary

1. For suicide prevention, it is important to see the suicidal person as an intentional agent, and the suicide attempt as a goal-directed action.
2. It is also important to let a person tell their suicidal story unhindered after a suicide attempt.
3. In the self-confrontation interview, we not only gain additional information about the experience of suicide history, but also make an important contribution to suicide prevention.
4. For suicide prevention, it is also important to initiate a joint life-oriented project with the suicidal person that goes beyond a single brief encounter.
5. The problems of action order, steering, monitoring and energization need to be addressed.
6. Life-sustaining action alternatives as a safety net must be worked out, and corresponding implementation intention must be built up.
7. The ASSIP combines these steps into successful suicide prevention.

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