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MEETING THE SUICIDAL PERSON

K.Michel, D. Jobes, A.A. Leenaars, J.T. Maltsberger, P. Dey, L. Valach, R. Young

THE GUIDELINES FOR CLINICIANS

The working group was unanimous in the view that current emergency room and clinic approaches to suicidal patients are too unempathic and unhelpful to succeed in drawing out patients' accounts of extreme pain and suffering in such a way so that the nature of their experience becomes clear, and a therapeutic alliance established. In clinical practice patients must be understood to act in order to escape intrapsychic pain, and their behavior put in the perspective of their life experiences.

The working group proposes that the following points should be taken into account if we want to improve the approach toward the patient who attempted or considers suicide.

1. The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality

The working group holds the view that the goal for the clinician must be to reach, together with the patient, a shared understanding of the patient's suicidality. This goal stands in contrast to a traditional medical approach where the clinician is thought to be the expert in identifying the causes of a pathological behaviour and to make a diagnostic case - formulation. It must be made clear, however, that in the working group's understanding a psychiatric diagnosis is an integral part of the assessment interview and must adequately be taken into consideration in the planning of further management of the patient. The active exploration of the mental state, however, should not be placed early in the interview.

2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.

Patients therefore are very vulnerable and have a tendency to withdraw. Experience suggests, however, that after a suicide attempt there is a "window" in which patients can be reached. Patients at this moment are open to talk about their emotional and cognitive experiences related to the suicidal crisis, particularly if the clinician is able to explore the intrasubjective meaning of the act with the patient.

3. The interviewer's attitude should be non-judgmental and supportive.

For this the clinician must be open to listen to the patient. Only the patient can be the expert of his or her own individual experiences. Furthermore, the first encounter with a mental health professional determines patient compliance to future therapy. An open non-pejorative approach is essential to support patients in reconsidering their goals.

4. The interview should start with the patient's self-narrative.

A suicidal crisis is not just determined by the present, it has a history. Suicide and attempted suicide are inherently related to biographical, or life career aspects and should be understood in this context. Therefore, the interview should start with the patient's self-narrative ("I should like you to tell me, in your own words, what is behind the suicide attempt...."). Explaining an action,

and making understood to another person what made the individual do it puts a suicidal crisis into perspective and can be instrumental in re-establishing the individual's sense of mastery.

5. The ultimate goal must be to engage the patient in a therapeutic relationship.

The meaningful discourse with another person can be the turning point for the patient in that life-oriented goals are re-established. This requires the clinician's ability to empathize with the patient's inner experience and to understand the logic of the suicidal urge. An interview in which the patient and the interviewer jointly look at the meaning of the suicidal urge sets the scene for the dealing with related life-career or identity themes. The plan of a therapy is so to speak laid out.

6. We need new models to conceptualize suicidal behaviour that provide a frame for the patient and clinician to reach a shared understanding of the patient's suicidality.

An approach that does not see patients as objects displaying pathology but as individuals that have their good reasons to perform an act of self-harm will help to strengthen the rapport. The most common motive is to escape from an unbearable state of mind (or the self). A theoretical model that understands suicide actions as goal directed and related to life-career aspects may prove to be particularly useful in clinical practice.

The group strongly feels that purely reductionist, quantitative research alone cannot fully reveal the complex processes that give rise to a person's suicidal behaviour. While quantitative research has helped guide clinical interventions, there is an increasing need for qualitative research focusing on the patients' own internal suicidal processes ass well as on interactive processes with professional helpers. We can expect that such research will add new dimensions to the existing knowledge of the suicidal process.