6TH AESCHI CONFERENCE, 20. - 23. MARCH 2011

Welcome to Aeschi 2011!

For those not familiar with the tradition of the Aeschi Conferences, let me take a quick look back. In the year 1999 Ladislav Valach and myself decided to invite some of the most renowned experts on psychotherapy for suicidal patients to join us here at the Hotel Aeschi Park in order to discuss our findings from the content analysis of video-recorded interviews with patients who had attempted suicide. So, in February 2000 we (David Jobes, Antoon Leenaars, John T. Maltsberger, Israel Orbach, Richard Young, Ladislav Valach, Pascal Dey, Kathrin Stadler and KM) met here for three days watching interviews, discussing therapeutic attitudes, exchanging experiences and developing new ideas. For all of us it was this strong and stimulating experience, which generated the "Aeschi spirit". All of us felt that the quest for patient-oriented models of therapy for suicidal patients should continue, and the circle of participants should be opened. Later, Michael Bostwick and Mark Goldblatt joined the Aeschi Working Group. Many more excellent experts and clinically oriented psychotherapists joined us in the following Aeschi conferences.

Sadly, this is the first year without Israel Orbach. He died unexpectedly, after a short period of illness in November 2010. This was a shock for us, and for the community of clinical suicide experts. On Monday evening at this conference we shall have a session dedicated to him and his work. Israel was the researcher who probably knew most about dissociation and mental pain in relation to suicide. That is to say, he was well aware of the association between internal (and external) traumatic pain and suicide. Very often, if not always, it is dissociation which paves the path for an act of self-harm, and, of course, dissociation is closely related to traumatic stress and the re-experiencing of trauma. Of course, the relationship between suicide and early trauma, such as sexual abuse, has been known for long. However, the neurosciences have added new dimensions. For instance, with the concept of epigenetics, researchers investigating gene x environment interactions have widened the focus for early trauma – the new word now is "childhood adversities", which encompasses a wide range of negative life events, such as maltreatment, domestic violence, separation, emotional neglect and so on. The question, of course, is, where we should draw the line – this will be a point to be discussed at this conference.

Clearly, we need to pursue our efforts to improve the theoretical concepts of suicide. However, in our therapeutic work we have to be open to listen to the patients' narratives and their accounts of inner pain and desperation. Empathic understanding of the suicidal wish – another major focus of Israel Orbach, as well as of the Aeschi Conferences – requires the ability of "tuning-in" with the suicidal person. From the many interviews with people who have attempted suicide I am convinced that most of them, prior to acting on a suicidal impulse, have an experience of mental pain, which has the qualities of an acute traumatic state. This may be related to a deep sense of personal failure, to a loss of the usual sense of self, to self-hate, and to rejection of the self. What often struck me is that patients who have experienced aggression against themselves report that in the suicidal crisis they acted as if they had internalised the perpetrators aggressive motives (e.g. I felt like dirt; he should have killed me). Can the *deconstruction of the self* (Baumeister) trigger a form of inner trauma? How can people learn to better cope with this? Can they internalize alternatives to the escape into suicide?

It is my hope that in this conference we shall further our knowledge and understanding of the suicidal person's traumatic pain, and how it could be targeted for therapeutic interventions.

Konrad Michel, 3/2011

P.S. Aeschi 2011, of course, is also the occasion to celebrate *"Building a Therapeutic Alliance wit the Suicidal Patient"* (APA Books, 2010). It is the result of ten years Aeschi, of which we, the authors, are all very proud. Of course, we hope that the volume will become a classic for clinical suicide prevention!

THE AESCHI GUIDELINES FOR CLINICIANS

1.) 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 in the role of 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 first in the interview, but follow a narrative approach.

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 prepared 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 empathic approach is essential to help patients re-establish life-oriented goals.

4.) 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 the clinician should aim at understanding them in this context. Therefore, the interview should encourage patients to deliver their self-narratives (”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 reestablishing the individual's sense of mastery.

5.) New models are needed to conceptualize suicidal behavior 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.

6.) The ultimate goal should be to engage the patient in a therapeutic relationship, even in a first assessment interview. In a critical moment in a patient’s life the meaningful discourse with another person can be the turning point 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.

Michel K, Maltsberger JT, Jobes DA, Leenaars AA, Orbach I, Stadler K, Dey P, Young RA, Valach L: Discovering the Truth in Attempted Suicide, American Journal of Psychotherapy 2002, 56/3, 424-437