Welcome to Aeschi 2009!

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 40 video-recorded interviews with patients who had attempted suicide. So, in February 2000 we (David Jobes, Antoon Leenaars, Terry Maltsberger, Israel Orbach, Richard Young, Ladislav Valach, Pascal Dey, Kathrin Stadler and myself) met here for three days watching interviews, discussing therapeutic attitudes, exchanging experiences and developing new ideas (hence the name Aeschi Conference). It was snowing outside and it was a strong and stimulating experience, which generated the "Aeschi spirit".

The Aeschi spirit is about patient-oriented models of therapy for suicidal patients. It is based on assumptions such as:

- The goal for the clinician must be to reach, together with the patient, a shared understanding of the patient's suicidality.
- 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.
- A suicidal crisis is not just determined by the present, it has a history.
- The ultimate goal should be to engage the patient in a therapeutic relationship, even in a first assessment interview.

The present 5th Aeschi Conference again gets experts together who are actively and creatively developing new and better ways to treat and care for people who are at a risk to die by suicide. A major question is how helpful inpatient treatment is for people who have attempted suicide. We all know that suicide risk during and after hospitalization is extremely high, and presently, nobody really knows when and for whom inpatient treatment is good at all. I believe that new models of active follow-up outpatient treatment are very promising and badly needed. But we have to find out what exactly will reduce the risk of further suicidal behaviour and how long follow-up should be. To hospitalize or not to hospitalize? This question is inextricably linked with the question what a good therapeutic relationship – a therapeutic alliance is. Therefore, in this conference, we shall have presentations and workshops focusing on this topic, and we hope that – similar to the first Aeschi Conference – sharing experiences will be stimulating and generate new ideas.

We further again have experts covering various therapeutic models with reference to the therapeutic relationship, such as mentalization, psychoanalytic therapy, CBT, DBT, and pharmacotherapy. And, of course, as always, the suicidal patients themselves, who are the true focus of Aeschi, shall be present through video-recorded interviews, followed by case discussions.

I am greatly thankful to Mark Goldblatt, Dave Jobes, and Terry Maltsberger for their great help in getting this program together and inviting the right people. We had many telephone conferences throughout the last year. I also thank the many presenters who made their way to Aeschi, Anja Maillart who greatly helped with the organization, and the sponsors who made this special meeting possible.

Konrad Michel, 2/2009

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.

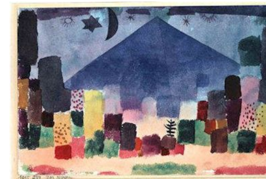
5.) New models are needed to conceptualize suicidal behavior that provide a frame for the patient and clinician to reach a shared understanding of the patient's suicidality. An approach that does not see patients as objects displaying pathology but as individuals that have their good reasons to perform 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.

University Psychiatric
Hospital Bern

5th Aeschi Conference Programme



WEDNESDAY, MARCH 4, 2009

20.00 Welcome Reception, Buffet Dinner

THURSDAY, MARCH 5, 2009

TREATMENT CONSIDERATIONS - BASIC ISSUES

Chairperson: D.A. Jobes

9.00 K. Michel: Therapeutic Alliance – An Old Hat?

9.20 J.T. Maltsberger: Commonalities of Effective Treatments

9.40 J. Allen: Mentalizing Suicidal States

10.00 General Discussion

10.30 Coffee break

11.00 Chairperson: M. Bostwick
Video-recorded Case Interview; Discussants: K. Comtois, M. Schechter
Followed by General Discussion

12.30 Lunch

Workshops ***PLEASE NOTE: CHANGE OF TIME SCHEDULE!***

14.00 – 15.15 M.M. Linehan, K. Comtois: University of Washington on-line Risk Management Treatment Protocols for Highly Suicidal Individuals

15.45 – 17.00
Room A J. Allen, D.A. Jobes, I. Orbach: Mentalizing, Self-hate, and Suicide

Room B J.T. Maltsberger, M. Goldblatt, E. Ronningstam, M. Schechter, I. Weinberg: Case Discussion: Establishing a Therapeutic Alliance With the Suicidal Patient

Plenum
17.15 – 18.30 Poster Session, Chairperson: L. Valach

18.30 **Dinner**

20.15 **Plenum**
M.D. Rudd: Facilitating Hope in Cognitive Therapy for Suicidality

FRIDAY, MARCH 6, 2009

TO HOSPITALIZE OR NOT TO HOSPITALIZE?

7.15 - 8.15 ***Early Bird Sessions***

Room A M. Perret-Catipovic: The Geneva Model: Suicide Prevention for Adolescents

Room B R. Fartacek, M. Plöderl, C. Fartacek: The Salzburg Model of Suicide Prevention: Research and practice in an inpatient Department of Suicide Prevention.

Plenum

Chairperson: I. Orbach

9.00 T. Lineberry: The Mayo Hospitalization Study

9.20 G.K. Brown: Engaging and Maintaining the Suicidal Patient in Treatment

9.40 K. Comtois: See You Tomorrow…: The Next Day Appointment

10.00 General Discussion

10.30 Coffee break

11.00 Chairperson G.K. Brown

Video-recorded case interview: Discussants: M.M. Linehan, J. Allen followed by General Discussion

12.30 Lunch

Parallel Workshops

14.00 - 17.00 (Break 15.00 - 15.30)

Room A K. Comtois, M. Plöderl, M. Perret - Catipovic, E. Rohrbach: Inpatient Care: For Whom and When?

Room B M. Goldblatt, K. Michel: Drugs And the Therapeutic Relationship

Room C D.A. Jobes (CAMS); M. Ring, G. Harbauer, S. Haas (PRISM): Patient-oriented Assessment Tools

Social Event

17.20 Bus departure

Apéro espagnol at the Restaurant Rathaus, Thun

20.10 Dinner at the Hotel Aeschi Park

SATURDAY, MARCH 7, 2009

7.15 - 8.15 ***Early Bird Sessions***

Room A Th. Reisch: Suicide Narratives in the fMRI

Room B A. Maillart/K. Michel: The Bern Short Intervention Project

SUICIDE PREVENTION: DO WE HAVE THE RIGHT MODELS?

Chairperson: K. Michel

9.00	P. Clayton: What Research Tells Us about Suicide
9.20	M. Bostwick: Pharmacotherapy for Suicidal Patients
9.40	M.M. Linehan: Models of Treatment for Suicidal Behaviour: An Empirical Comparison of Efficacy
10.00	General Discussion
10.30	Coffee break
11.00	D.A. Jobes: New Frontiers in Treatments of Suicidality Followed by General Discussion
12.00	Lunch

End of Conference

Afternoon: Excursion
(optional, not included in conference fee, tickets at registration desk)

13.30 Bus departure

Participants staying for dinner at the Hotel should buy a dinner voucher at the registration desk

American Foundation *for* Suicide Prevention

Main Sponsor

ABSTRACTS

PLENARY SESSIONS

THURSDAY, MARCH 5, 2009

K. Michel: Therapeutic Alliance – An Old Hat?

The therapeutic alliance has always been central to the Aeschi movement. The goal in a therapeutic encounter with suicidal patients must be to achieve the experience of working together in such a way that the patients allows a therapist to enter their personal world in order to initiate a process of intrapsychic change. Trust within the patient-therapist dyad is the prerequisite for such an extraordinary thing to happen between two people. A therapist who has a patient-oriented professional attitude and a patient who is motivated to share his or her inner experience are the essential elements of a therapeutic interpersonal dynamic. The Aeschi Group believes that such principles are particularly valid for short-term hospitalizations after attempted suicide. A therapeutic milieu includes an empathic presence of the staff. Unfortunately, contemporary clinical practice in Europe as well as in the USA is often far away from the ideal setting for suicidal patients.
Mr. D.S. in interview with K. Michel, 1/2009, age 30, describes treatment following attempting suicide, New York City, 2004. *Duration of video: 15:35 min.*
P.S. Colleagues from the USA should not take this report personal!

J.T. Maltsberger: Commonalities of Effective Treatments

A number of empirically supported new treatments for borderline personality disorder patients attempting suicide have been put forward. A group of us from Boston (we call ourselves the Boston Suicide Study Group) studied five of these methods, systematically comparing and contrasting the published treatment manuals that describe them. This morning I will summarize what we found, highlighting the important similarities and differences. We believe we have identified about seven characteristics all the effective treatments have in common.

J. Allen: Mentalizing Suicidal States

Suicidal states often entail a sense of being alone in unbearable emotional pain, an experience that can replicate early trauma. Establishing a therapeutic empathic connection and assisting patients in regulating emotion requires *mentalizing*—awareness of mental states in self and others. Mentalizing capacity is undermined by a history of attachment trauma, potentially contributing to reenactment and reexperiencing of trauma, at worst, culminating in suicidal states. This presentation illustrates how contemporary treatment protocols, such as Jobes's Collaborative Assessment and Management of Suicidality, provide helpful structure that supports therapists' as well as patients' mentalizing capacity in the midst of patients' suicidal states.

Video-recorded Case Interview

Discussants: K. Comtois, M. Schechter

Mr. S. in interview with Anja Maillart, 12/2008, following suicidal crisis, age 36, BDI 16 (=depression, moderate degree). *Duration of video: 17 min.*

M.D. Rudd: Facilitating Hope in Cognitive Therapy for Suicidality

Recovery following a suicidal crisis is about building and maintaining hope, particularly for longer term resilience. Hopelessness is the most potent individual predictor of suicide across the lifespan. The current session will discuss the construct of hope, along with detailing a range of techniques and interventions for building and maintaining hope throughout the duration of care.

FRIDAY, MARCH 6, 2009

T. Lineberry: The Mayo Hospitalization Study

Dr. Lineberry will describe current efforts at improving suicide risk assessment and management at the Mayo Clinic Psychiatric Hospital. He will present a background on the challenges associated with developing suicide risk assessment instruments tools which are clinically relevant. Dr. Lineberry will review the collaboration between Mayo Clinic and Catholic University in validating the Suicide Status Form-II with psychiatric inpatients. He will also describe how this has been clinically integrated into Mayo's hospital practice, defining particular points to assess progress during hospitalization, and how to communicate this in a multidisciplinary format. He will close with a discussion of new outcomes research using their suicide assessment in patients who are chronically suicidal versus acutely suicidal and review the implications of changing practice and the challenges therein.

G.K. Brown: Engaging and Maintaining the Suicidal Patient in Treatment

We are about to launch a very large emergency department study and treatment engagement is at the top of the list. This will also give me a chance to talk about Safety Planning, a treatment that I've developed with Barbara Stanley, that is currently being widely used in the US.

K. Comtois: See You Tomorrow…: The Next Day Appointment

Many patients come to the hospital in suicidal crisis - either to the emergency room alone or hospitalized on a medical or psychiatric unit. If they don't have an outpatient mental health clinician or have not seen their clinician in some time, it can be very difficult to arrange a hospital discharge. In Seattle in the US, the solution that has been developed is a "next-day appointment" (NDA) where a clinic has set aside appointment times the hospital can use to give the patient a specific follow-up session. However, what happens in that appointment is the big question... does it help? does it hurt? what can we do to make it better? This talk will describe usual care referral and use of NDAs as well as a clinical trial using CAMS to improve NDA care.

Video-recorded case interview

Discussants: M.M. Linehan, J. Allen

Ms. C.R., in interview with K. Michel, 1/2009, following overdose and cutting, age 23, BDI 22 (=depression, moderate degree). *Duration of video: 17 min.*

SATURDAY, MARCH 7, 2009

P. Clayton: What Research Tells Us about Suicide

In the United States, as indicated from the 2005 data, suicide is the 11th leading cause of death. The most important risk factor for death by suicide is having a mental disorder. Although the data from psychological autopsy studies vary by investigator, access, instrument and procedures used and country, the overwhelming majority of the 115 studies, regardless of the age of the deceased, indicate that about 90 % of those who kill themselves are suffering from a mental disorder. Data related to this statement will be reviewed in greater detail. Following that, other risk factors for suicide will be summarized and the data from various intervention studies will be reviewed. The presentation will concentrate, for the most part, on an outcome of suicide in order to emphasize that the ultimate goal, at least for AFSP, is to prevent suicide.

M. Bostwick: Pharmacotherapy for Suicidal Patients

The Aeschi approach assumes that each patient has a unique suicide narrative to which treatment must be tailored. While verbal and cognitive approaches feature prominently in facilitating clinicians joining patients in crisis and helping them find their way through and beyond the storm, pharmacotherapy offers an additional modality for breaking the drive toward lethal action. The chronology of the suicidality -- acute vs. chronic, new-onset vs. recurrent, episodic vs. characterologic, free-running vs. stress-induced -- will suggest the appropriate classes of medications to try. Both stress and diathesis may respond favorably to pharmacologic intervention, and medication will inevitably work better when prescribed in a psychodynamically informed, relational context.

M.M. Linehan: Models of Treatment for Suicidal Behaviour: An Empirical Comparison of Efficacy

see separate abstract

D.A. Jobes: New Frontiers in Treatments of Suicidality

In spite of the pervasiveness of suicidal patients in clinical work, research and practice approaches that effectively treat suicidal risk have historically not necessary met the needs of clinicians. While there has been a virtual explosion in suicide-related research over the past 25 years, much of it has not focused specifically on clinical treatments for suicidal patients. However, in more recent years, an increase in treatment research has begun to make some meaningful contributions to our knowledge base. Moreover, various clinical approaches across theoretical orientations have increasingly been developed that focus on suicide-related clinical treatments. This presentation will thus review major developments in the treatment of suicidal risk from both an empirical and clinical perspectives with a particular emphasis on the Aeschi approach to suicide risk.

EARLY BIRD SESSIONS

FRIDAY, MARCH 6, 2009

M. Perret-Catipovic

The Geneva Model: Suicide Prevention for Adolescents

Destiné à accueillir les jeunes de 16 à 21 ans, le centre ambulatoire de traitement intensif (CATI) a débuté son activité aujourd'hui au 20 avenue Beau-Séjour, grâce à une contribution majeure de la Fondation CHILDREN ACTION. Complétant le dispositif genevois de prévention et de traitement hospitalier des crises associées à des idées suicidaires à l'adolescence, cette nouvelle structure offre des soins ambulatoires urgents ainsi qu'un suivi sur 8 à 12 semaines. Alternative à l'hospitalisation, elle facilite la poursuite de l'activité scolaire ou professionnelle pendant la durée du traitement. Créée en 1996 par les HUG et généreusement soutenue par la Fondation CHILDREN ACTION, l'unité de crise pour adolescents suicidants et le centre d'étude et de prévention du suicide sont désormais complétés par un volet ambulatoire garantissant le suivi des adolescents en difficulté au long cours. Cet ensemble (prévention, soins ambulatoires, traitement hospitalier) se profile comme un centre d'excellence universitaire et un modèle en Europe.

R. Fartacek, M. Plöderl, C. Fartacek: The Salzburg Model of Suicide

Prevention: Research and practice in an inpatient Department of Suicide Prevention

SATURDAY, MARCH 7, 2009

The suicidal brain: An fMRI pilot-study

T. Reisch[1], E. Seifritz[2], F. Esposito[4], R. Wiest[5], L. Valach[6], K. Michel[1]

1)University Hospital of Psychiatry Bern, Switzerland, 2) Sanatorium Kilchberg, Zürich, Switzerland, 3) Neurological Sciences, University of Naples, Italy, 5) University Hospital of Neuroradiology, Bern, Switzerland, 6) Private Practice, Bremgarten, Switzerland

OBJECTIVE: The neuronal activation associated with the recall of attempting suicide was studied. METHOD: Patients who recently had attempted suicide were asked to participate in a narrative interview focusing on the circumstances of the suicidal crisis. Interviews were transcribed and sequences containing descriptions of (1) mental pain, of (2) suicide action, and of (3) neutral activity were used for script-driven recall during fMRI scanning. RESULTS: Areas of frontal deactivation were found during both, recall of mental pain and suicide action. More specifically, mental pain was associated with a deactivation in the left middle prefrontal cortex and the anterior cingulate cortex. This pattern was reversed in the suicide action condition. CONCLUSIONS: The results are consistent with a two-phase model of suicidal behavior, with an experience of mental pain, followed by a suicide action whose goal is to find relief of a mental state which is deemed unbearable by the individual. The neural correlates of mental pain suggest an experience comparable with traumatic stress. The traumatic nature of mental pain is supported by patients' reports of symptoms of dissociation. A two-phase model of suicidal behavior may help the development of specific treatments focusing on strategies of coping with mental pain.

The Bern Attempted Suicide Short Intervention Program ASSIP

A. Maillart[1], K. Michel[1], T. Reisch[1], H.-J. Znoj[2], Bern
[1] University Hospital of Psychiatry Bern, Switzerland [2] University Institute of Psychology, Bern, Switzerland

This short intervention program includes 4 sessions, followed by sending standardized letters over 2 years, an emergency card for contact in case of emergency, and is based on the assumption that even a short intervention, if it is relevant to the patient, may provide an "anchoring" (secure base) which may be protective in future suicidal crisis. The program encompasses a narrative interview carried out by a trained interviewer, followed by a video-playback session, with subsequent analysis of the suicidal development in close collaboration with the patient. This includes a reconstruction of the patients' narrative and identification of the main life-career issues expressed by the patient in connection with the suicide attempt. A written formulation of the analysis and contingent individual behavioral strategies is handed to the patient, the therapist and, if applicable, to the GP. Note: This program does not replace a mid- or long-term therapy.

The program will be evaluated over a time course of 2 years. Patients are allocated to the intervention group and a control group, where patients receive a standardized clinical interview, with written info about prevention of suicide. The evaluation instruments include, among others, the BDI, the Beck Suicide Ideation Scale, and the SSF-II.

ABSTRACTS

WORKSHOPS

THURSDAY, MARCH 5, 2009

University of Washington on-line Risk Management Treatment Protocols for Highly Suicidal Individuals; *M.M. Linehan, K. Comtois*

Since 1991, the Behavioral Research and Therapy Clinics (BRTC) at the University of Washington has enrolled over 250 individuals selected for treatment due to high risk for suicide as well as many others with episodic suicidal behaviors. All clients have participated in either dialectical behavior therapy (DBT) or a control treatment. All therapists at the BRTC, whether providing DBT or a control treatment, have also used our University of Washington Suicide Risk Assessment and Management Protocol (U-RAMP) developed initially for DBT but compatible with any biological or psychosocial intervention. To facilitate use of the U-RAMP, we have developed an on-line version of the U-RAMP note with the expectation that requirements to fill out the note under well defined circumstances would increase the use of standardized crisis management procedures that combined make up the UW S-RAMP. The focus of this workshop is a review of the U-WRAMP as well as a companion University of Washington Risk Assessment Protocol (U-WRAP) developed for use by clinical assessors in research studies.

Mentalizing, Self-hate, and Suicide

Jon Allen: Developing an Internalized Secure Base through Attachment and Mentalizing.
In this workshop we shall examine the use of mentalizing as a potential treatment approach to working with extreme suicidal self-hatred. The presentation reviews the intergenerational transmission of secure and insecure attachment patterns in relation to mentalizing, with particular attention to early attachment trauma. Such trauma compromises the development of mentalizing capacity and thus has the potential to undermine attachment relationships with other persons as well as the relationship with oneself. Mentalizing is construed as a common factor in diverse psychotherapeutic approaches; in addition, mentalizing in psychotherapy is proposed as being essential to the development of an internalized secure base that is needed to counter the self-hatred common among persons vulnerable to suicidal states.

David A. Jobes: Certain suicidal patients who experience many years of chronic suicidal risk can develop a treatment resistant form of self-loathing where suicide can seem like the only viable means of escape. Years of clinical research using the Suicide Status Form (SSF) provides different perspectives on suicidal self-hatred (with implications for relational aspects of suicide as well). The mental pain of suicidal self-hatred will be examined in depth and new treatment targeting this kind of suffering will be discussed. Case examples of extreme suicidal self-hatred will be presented for discussion with participants.

Israel Orbach: Impoverishment of self-esteem is present in almost all pain narratives of suicidal individuals. In some cases, this is a direct result of internal or external trauma or loss. In other cases, there is an active depletion of the self-esteem by the sufferer. In both cases, the sufferers feel completely drained of self-love and esteem and adopt a derogatory attitude toward themselves. It seems that self-esteem and mental pain influence each other reciprocally. The experience of mental pain in one way or another depletes one's self-esteem and, in turn, increases the experienced mental pain. This process is found in all pain stories. These processes will be demonstrated through several case studies.

Case Discussion: Establishing a Therapeutic Alliance With the Suicidal Patient;

J.T. Maltsberger, M. Goldblatt, E. Ronningstam, M. Schechter, I. Weinberg

While it is tempting to expect that the positive quality of the alliance will protect against suicide, the clinical experience as exemplified by the vignettes above, argues that the therapeutic alliance in itself is insufficient. Although it is a critical component for successful treatment (Sandler et al. 1992), the therapeutic alliance cannot be counted on in all psychotherapies of suicidal patients. At times it can be a profound life-saving connection, and at other times, it is an illusion, a false hope conjured up by the therapist, with no basis in the real therapeutic relationship. An alliance with suicidal patients, particularly around suicidal crises, is sometimes possible. However, it may not be present with certain kinds of patients, and can change as circumstances change during the course of treatment. When present, the therapeutic alliance is a strong anti-suicide factor, but it fluctuates and is influenced by several factors including the suicide dynamics.

The review suggests that although most patients exhibit some capacity for developing a therapeutic alliance, this alliance is modified by alliance-interfering and alliance facilitating factors. The weight of each of these factors at a particular stage of therapy determines whether the alliance is protective or not. The therapeutic alliance with suicidal patients should therefore be carefully reassessed throughout the therapy.

FRIDAY, MARCH 6, 2009

Inpatient Care: For Whom and When?

Kate Comtois: Inpatient hospitalization is the standard of care for suicidality in many countries around the world including the US. Few studies have examined the effectiveness of hospitalization in preventing suicide or suicide attempts and, of those, no study has found hospitalization to be effective. On the other hand, several outpatient interventions have shown themselves to be effective (although few in replications or large trials). Given this lack of empirical direction, this talk uses health services and behavioral perspectives to examine the use of hospitalization (for whom, what, when, where, and how), its impact on suicidal individuals, and potential alternatives.

Martin Plöderl, Clemens Fartacek, Karl Kralovec, Günther Schiepek, Reinhold Fartacek:
Hospitalization among chronically and nonchronically suicidal individuals. There is a debate about which suicidal individuals profit from hospitalization. On the one hand, hospital admission in case of acute suicidality is best practice according to established guidelines. One the other hand, however, hospitalization may even increase suicidality, especially among "chronically suicidal" individuals. The empirical investigation of this research question is problematic, because there is no consistent definition of chronic suicidality. Therefore, our presentation summarizes existing definitions of chronic suicidality and describes the development of an assessment procedure. We then present an empirical study to investigate the benefit of hospitalization in relation to the chronicity of suicidality and to other possible predictors of treatment success. In addition to established pre- and post-measures, we will use a nonlinear dynamics approach, i.e., analyzing time series with the "Synergetic Navigation System". This allows an insight into the treatment process from a synergetic viewpoint.

Maja Perret – Catipovic: Le centre ambulatoire de traitement intensif (CTAI) venant compléter l'UCA et le CEPS. Cette nouvelle structure offre des soins ambulatoires urgents ainsi qu'un suivi sur 8 à 12 semaines. Alternative à l'hospitalisation, elle facilite la poursuite de l'activité scolaire ou professionnelle pendant la durée du traitement. Le CTAI propose, sur la base d'un contrat volontaire, une prise en charge ambulatoire intensive. Depuis son ouverture le CTAI a suivi 91 adolescents qui avaient besoin d'un suivi après un séjour hospitalier ou qui traversaient une crise avec des idées suicidaires, voire qui avaient réalisé une tentative de suicide mais refusaient les contraintes d'une hospitalisation.

Elisabeth Rohrbach: Regressive Treatment: A therapy principle for suicide prevention. In any severe depression there is an increased risk for suicide. Depression is an inhibition of psychic functions on the basis of an intrapsychic conflict. Psychic functioning is therefore possible only on a regressive level. For a depressive patient psychic functioning on such a regressive level becomes possible and the suffering from depression is mitigated and becomes more tolerable. In a regressive treatment of depression patients are permitted to be regressive – it is even the prescribed treatment. So the suicidal situation may calm down, that is triggered as by the inner conflict of the super-ego as by the real and supposed demands of the social objects of the patient.

Drugs And the Therapeutic Relationship

M. Goldblatt, K. Michel

Ideally, medication is part of an overall concept of therapeutic interventions, which should be understandable and transparent to the patient. Needless to say, a good therapeutic relationship implies that the patient's and the therapist's goals of treatment are largely congruent. Medication will then be seen by the patient as a helpful therapeutic element which is an integral part of the therapeutic process.
Prescribing psychotropic drugs to suicidal patients is a special challenge. Reasons:

- Some drugs may increase suicidality
- Some drugs are highly toxic in overdose
- Suicidality (particularly after attempted suicide) is a long-term risk and may require long-term medication
- Suicidality is often associated with axis 2 disorders which require complex treatment protocols
- Drugs are prescribed for psychiatric disorders associated with increased risk of suicide, however, suicidal persons often see suicide as a personal matter, more related to psychological processes
- Evidence for an antisuicidal effect of psychotropic drugs is scarce.

In the workshop, practical aspects of how a strong „pharmacotherapeutic relationship" can be achieved will be discussed.

Patient-oriented Assessment Tools

David A. Jobes: The Collaborative Assessment and Management of Suicidality (CAMS).
The Collaborative Assessment and Management of Suicidality (CAMS) is a clinical approach designed to quickly identify and engage suicidal patients in their own clinical care. Central to CAMS is the use of a multi-purpose assessment, treatment, and tracking tool called the Suicide Status Form (SSF). This presentation will focus on the SSF as a unique patient-oriented approach with both quantitative and qualitative assessment aspects. This presentation will examine both the psychometrics of the SSF and research use of the SSF with different samples of suicidal patients. In addition, this workshop will also examine the clinical use of the SSF and its particular application in CAMS.

Marianne Ring, G. Harbauer, S. Haas (PRISM): "a picture says more than thousand words" PRISM (Pictorial Representation of Illness and Self Measure) - a brief nonverbal method to ameliorate the assessment of suicidality.
The burden of suicidality is immense on patients but complex and difficult to describe, let alone to measure. The nonverbal visualization technique - the **P**ictorial **R**epresentation of **I**llness and **S**elf **M**easure (PRISM) has been developed as a tool for measuring 'the perceived burden of suffering due to physical illness' and has been used effectively in routine clinical practice (Büchi et al. 2002). We adapted the PRISM task for the assessment of the suicidality of patients admitted to an inpatient centre for crisis intervention. PRISM-S proved to take less than five minutes to complete and is unique in relying only minimally on language. PRISM-S was easy to apply and it revealed to be a simple tool to

facilitate clinician-patient communication. In the workshop, we will present and demonstrate the application of PRISM-S as a simple assessment instrument for suicidality.

References: Büchi S., Buddeberg C., Klaghofer R., Russi, E.W., Brändli O., Schlösser, C., Stoll, t., Villiger P.M., Sensky T. (2002) Preliminary validation of PRISM (Pictorial Representation of Illness and Self Measure)- A brief method to assess suffering. Psychother Psychosom 71: 333-341

ABSTRACTS

POSTERS

Firearm suicides and availability of firearms in the Swiss cantons

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We examined the association between the availability of firearms at home, and firearm suicide in Switzerland. Firearm suicide data 1996-2005 by canton were extracted from the Swiss mortality statistics, and data on firearms ownership by canton was taken from the Swiss Crime Victims Surveys for the years 1998, 2000 and 2005. Each series was averaged over the whole period. The correlation between the series is fairly high (rho=0.52). Swiss data shows that the association is generalizable at different aggregation levels (international and sub-national), suggesting the need for urgent preventive efforts.

Suizidversuche türkischer Migranten im Kanton Basel-Stadt, 2003 und 2004, im Vergleich mit Suizidversuchen der Schweizer Bevölkerung; WHO/EURO Multicenter Study on Parasuicide

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Im Rahmen der WHO-Multizenter-Studie zur Erfassung von Suizidversuchen wurden in den Jahren 2003 und 2004 im Kanton Basel-Stadt alle Suizidversuche erfasst. Dabei zeigten sich unerwartet hohe Suizidversuchsraten unter den türkischstämmigen Migranten. Es wurde der Frage nachgegangen, inwieweit sich das suizidale Verhalten türkischstämmiger Migranten von dem der Schweizer Bevölkerung unterschied.

Methodik: Als türkische Migranten wurden in der Studie alle Personen definiert, die in der Türkei geboren worden waren oder einen türkischen Pass besassen. „Suizidversuche" wurden nach den WHO-Richtlinien definiert. Sämtliche Spitäler, Psychiatrie- und Hausarzt-praxen erfassten Suizidversuche der Kantons-Einwohner vom 1.1.2003 bis 31.12.2004. Zudem wurden standardisierte klinische und soziodemographische Daten erhoben. Die Daten der türkischstämmigen Migranten und der Schweizer wurden mittels t-Tests respektive χ^2-Tests miteinander verglichen.

Resultate: Im Erhebungszeitraum wurden 56 Suizidversuche türkischstämmiger Migranten und 292 Suizidversuche von Schweizern erfasst. Die Migranten hatten eine Suizidversuchsrate/ 100'000 Einwohner von 467, die Schweizer von 123. Das mittlere Alter war bei den Migranten mit 31.4 Jahren signifikant tiefer als bei den Schweizern mit 39.9 Jahren. Bezüglich der klinischen ICD-10-Hauptdiagnosen sowie der angewandten Methoden fanden sich signifikante Unterschiede zwischen den Gruppen.

Diskussion: Die Suizidversuchsrate türkischer Migranten in Basel-Stadt war im Erhebungszeitraum viermal höher als die Suizidversuchsrate der Schweizer und sechs- bis zehnmal höher als die Suizidversuchsraten in der Türkei. Junge Frauen stellten in beiden Kollektiven eine Risikopopulation dar. V.a. bei türkischstämmigen Migranten ist in der Verschreibungspraxis von Benzodiazepinen und Analgetika auf möglichst niedrige Dosierungen und kleine Packungsgrössen bei Abgabe zu achten.

Building Trust in First Encounters with Patients after Attempted Suicide

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Aim: The main risk factor for suicide is attempted suicide. It boosts the risk of further attempts and heightens the risk of subsequent suicide considerably. We know that from the first encounter on, the quality of the therapeutic alliance plays an important role in the patient's motivation to continue the therapeutic relationship, and secondly the rate of suicide attempters willing to attend even a simple aftercare appointment to be alarmingly low; which implies the exigent urgency to offer these patients a helping and trustworthy relationship from the beginning, since we might only get this one chance to reach the patient. The aim of studying the clinician's style of interacting, ultimately leading to a 'good' or 'bad' encounter, is to diagnose 'good' or 'bad' ways of treating these patients.

Methods: Out of 40 videotaped narrative interviews (first encounter) with patients after attempted suicide, some of the 'best' and 'worst' encounters were thoroughly transliterated following GAT (Selting et al. 1998) and subsequently analysed by means of conversational (e.g. Deppermann 2001) and interactional (e.g. Streeck 2006) analysis. Patient's evaluation with the *Penn Helping Alliance Questionnaire* (Alexander & Luborsky 1990) serves as the independent quality criterion.

Results are obtained on three interdependent levels, each clearly dividing 'good' from 'bad' encounters: (a) the basic structure of the conversation, (b) the style of interacting and (c) the level of enacting dyadic constellations.

Discussion: 'Good' and 'bad' encounters are remarkably distinguishable inter se, especially considering the therapist's interaction. While certain interactive behaviours clearly are beneficiary, others aren't.

Web Integration of Clinical Decision Support System for Screening and Assessment of Suicide Risk

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Studies indicate that Suicide is generally a complication of a psychiatric disorder. More than 90% of suicide victims have a diagnosable psychiatric illness, and most people who attempt suicide have a psychiatric disorder. Moreover, 50% of people who commit suicide had sought professional help within one month of the act. This fact affords an opportunity for prevention. The high level of medical intervention before suicide is possible and effective prevention. Careful assessment of physical and psychological symptoms including personal and family history can indicate the degree of suicide risk. Based on the assessment, more effective recognition and treatment of depressive illness may substantially reduce suicide rate. In this talk, we will present a new clinical decision support system for improving mental health risk screening and assessment. The system will contain a tool for risk screening, recording patients' data, and providing risk assessment for suicide. Our developed system takes both patients' records and expert knowledge based classification criteria as inputs, and gives the quantified risk prediction. Based on the prediction, the targeting intervention plan can be provided. The potential users of the system are front line and second line mental health service workers. The health and social benefit of this system include earlier identification of people at risk, reducing suicide rate, educating and training of mental-health service providers, increasing public awareness of mental-health risk and appropriate interventions.

Short intervention project for suicide attempters referred to inpatient care

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University Hospital of Psychiatry Bern, Switzerland

Outpatient follow up is the preferred treatment modality for patients after a suicide attempt. However, a major percentage of the suicide attempters are voluntarily or involuntarily referred to inpatient care. Main reasons to choose this treatment modality are e.g. persisting suicidal ideation and little psycho-social resources. Treatment as usual for such inpatients consists of a short stay on the locked inpatient ward and usually includes a basic medical and psychological evaluation, close observation and daily short unspecific interactions with the resident. Suicide attempters often described such treatment as controlling rather than caring.

As an extension of the "Attempted Suicide Short Intervention" for suicide attempters developed by Michel and Maillart, the Bernese Suicide Working Group is currently developing an extended program for suicide attempters referred to inpatient care.

The general idea of the project is to offer a supporting environment plus specific therapeutic interventions adapted to the patient's needs. Within the project, the patient is followed up by the same therapist until stabilization, independent of the therapy modality (inpatient care, partial hospitalisation, or outpatient treatment). In addition to the interventions already used in the outpatient program (narrative approach, video feedback, emergency card, regular letters) we will also include the following interventions: first aid box (stress tolerance skills), fire alarm (activation of external resources as help to register future deterioration), and response prevention task (in vitro exposure technique, see Brown et al.). In the first step of implementation, we will investigate the feasibility of the various interventions. In the poster we shall describe the interventions and put to discussion the pros and cons of the project.

Hospitalization and Significant Others of Suicidal people: experiences, needs and challenges

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Scientific literature on significant others of suicidal people is scarce. Little is known, for example about how they live through and deal with suicidal behavior. Supported by the University of Applied Sciences Research Found an exploratory qualitative study was conducted in two Swiss cantons (Fribourg and Valais) from March 2007 to March 2008. 20 semi-structured interviews with significant others were conducted in order to investigate a) individual and family experiences in dealing with suicidal behavior b) roles and support provided (or not) by significant others faced with suicidal behavior c) significant others' help seeking strategies for the suicidal person and for themselves d) significant others' needs in this situation. The poster will present findings regarding hospitalization across these four points.

Content analysis showed that even if supporting a suicidal loved one is a demanding experience and task, significant others provide several types of support. If aware of the suicidal risk, they usually seek help, turn to professionals and consider hospitalization as an appropriate option, even if they might be ambivalent about that. The access to professional support and to the chain of care seems often complicated and difficult though. Relationships with hospital professionals are complex, showing a need of mutual understanding of each other's logic and priorities. Significant others express the wish to: a) receive more information about the suicidal process and treatment, b) be considered as true partner by the professionals, c) be supported when the suicidal person is discharged, in order for them to be more helpful and understanding.

The suicidal brain: An fMRI pilot-study

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For abstract see early bird session on Friday, 6th March 2009

Suicidal thoughts and behaviors among high school students

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One of the strongest factors in predicting adolescent suicide is whether or not the adolescent has suicidal thoughts (American Foundation for Suicide Prevention). Other risk factors of adolescent suicide include drug use, access to firearms, and sexual assault. Using data from the 2007 Youth Risk Behavior Survey (YRBS) in the United States, patterns in suicidal thoughts and behaviors are examined among high school students. Results indicate that there are clear predictors to both suicidal thoughts and suicide attempts, although the patterns are different for males and females.

Suicide trends diverge by method: Swiss suicide rates 1969-2005

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We examined the change in Swiss suicide rates since 1969, breaking down the rates according to the method used. The descriptive analyses of the main suicide methods are presented. The suicide rates reached a peak in the late 1970s / early 1980s and declined in more recent years. Firearm suicides and suicides by falls were the exception and sustained their upwards trend until the 1990s. Suicide by vehicle exhaust asphyxiation showed a rapid decline following the introduction of catalytic converters in motor vehicles. No substantial method substitution was observed. Suicide by poisoning declined in the 1990s but rose again following an increase in assisted suicide in somatically incurable patients. Suicide is too often regarded as a homogeneous phenomenon. With regard to the method they choose, suicide victims are a heterogeneous population and it is evident that different suicide methods are chosen by different people. A better understanding of the varying patterns of change over time in the different suicide methods used may lead to differentiated preventive strategies.

Attempted Suicide Short Intervention Program ASSIP

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For abstract see early bird session on Friday, 6th March 2009

Suicide in the Canton of Zug 1991 - 2007

Margrit Walti-Jenny, Hanspeter Walti, Matthias Bopp

Dear Konrad,
I have just returned from a big trip to China and Australia. I am having very fond nostalgic memories of Aeschi as I read your e-mail about the next conference. I very much would have loved to be present, and I am not going to be.
I want to take this time to wish you and all the conference organizers, presenters and participants the very best and an enjoyable and productive time period.
I wish all the conferences can be like yours.
Thank you for sending me the info. I will follow through with the proceedings
With very warm regards
Savi Anthony

THE AESCHI EXPERIENCE

Breathtakingly beautiful
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Unspoilt and pure
Tucked away from the world

Nations gathered
People mingled
Ideas shared
Concerns discussed
Thoughts developed
To serve others
In alleviating anguish

Interactive and dynamic
Knowledgeable and innovative
Research, lectures and workshops
Presented with clarity
Inspiring us to move forwards

Motivation maintained
Enthusiasm retained
Curiosity aroused
Hope rekindled
Hearts glowing warmly
We take our leave
Feeling happy and fulfilled

Savi Anthony, M.D.
New Zealand/2006