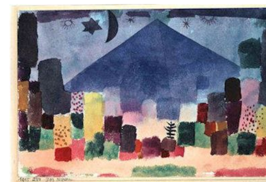
University Psychiatric
Hospital Bern

Programme

6th Aeschi Conference

Patient-oriented Concepts of Suicide:
Trauma and Suicide



SUNDAY, MARCH 20, 2011

20.00 Welcome Reception, Buffet Dinner

MONDAY, MARCH 21, 2011

Plenum

Chairperson: L. Valach

9.00 K. Michel: Introduction

9.15 Video-recorded Case Interview; Discussants: M. Schechter, D.A. Jobes
Followed by General Discussion

10.30 Coffee break

11.00 U. Schnyder: The Experience of Trauma in PTSD

11.30 M.D. Rudd: Dissociation and the Suicidal Mode

12.00 Discussion

12.30 Lunch

14.00 – 15.15 **Parallel Workshops**

Room A M. Goldblatt, J.T. Maltsberger, E. Ronningstam, M. Schechter: Trauma and Suicide: The Case of Peter F. Part 1

Room B D.A. Jobes, M. Holloway, M.D. Rudd: Combat Related Trauma and Suicide: Concepts of Therapy

15.45 – 17.00 **Parallel Workshops**

RoomA M. Goldblatt, J.T. Maltsberger, E. Ronningstam, M. Schechter: Trauma and Suicide: The Case of Peter F. Part 2

Room B K. Michel, A. Malafosse: Genetic and Neurobiological Aspects

Room C D. Jobes: SSF/CAMS Update and Feedback Session

Plenum

17.15 – 18.30 Poster Session, Chairperson: L. Valach

20.15 **Plenum** – Chair: K. Michel; I. Weinberg, L. Firestone: Suicide and Trauma, Dissociation, and Mental Pain – Session in Memory of Israel Orbach

TUESDAY, MARCH 22, 2011

7.15 - 8.15 **Early Bird Sessions**

Room A G.K. Brown: Safety Planning: A Brief Intervention to Mitigate Suicide Risk

Room B R. Young, L. Valach: Trauma Narratives

Plenum

Chairperson: G.K. Brown

9.00 K. van Heeringen: The Vulnerability Concept in Suicide Research

9.25 M. Bostwick: Adverse Childhood Experience and Susceptibility to Suicidal States

9.50 J. T. Maltsberger: The Traumatic Experience of Intolerable Affective States

10.15 General Discussion

10.30 Coffee break

11.00 Chairperson M. Bostwick
Video-recorded case interview: Discussants: M. Goldblatt, A. McQuillan, followed by General Discussion

12.30 Lunch

14.00 – 15.15 **Parallel Workshops**
Room A A. Andreoli: Traumatic Mourning Focused Psychoanalytic Psychotherapy (TMFPP) among acutely suicidal borderline patients: clinical potential and treatment technique

Room B M.D. Rudd: Cognitive Behavior Therapy for Suicidality (based on a clinical case)

15.45 – 17.00 **Parallel Workshops**
Room A H. Hjelmeland, B. Knizek: Qualitative Research in Suicidology: Challenges and Opportunities

Room B A. Beautrais, P. Wong, T. Vila, A. Habenstein, A. Maillart, K. Michel: Attempted Suicide: Should Therapeutic Interventions Start Right in the Emergency Room?

Social Event

WEDNESDAY, MARCH 23, 2011

7.15 - 8.15	**Early Bird Sessions**
Room A	L. Firestone: Trauma and the Critical Inner Voice
Room B	S. Kupferschmid: The Destiny of Kronprinz Rudolf II. (1858-1889): Parental Effects on Development and Epigenetics from the Perspective of a Historic Suicide
Room C	I. Weinberg: Traumatic and Suicidal States: Examination of the Relationship

Plenum

Chairperson: R. Young

9.00	A. McQuillan: Borderline Personality Disorders and Trauma
9.30	Heidi Hjelmeland: Do We Have the Right Research? Some Reflections on the Best Way Forward
10.00	Coffe break
10.30	Chairperson: K. Michel Panel discussion: Does the Trauma Concept Get Us Further in Suicide Research? D.A. Jobes, M.D. Rudd, T. Lineberry, K. van Heeringen, A. McQuillan
11.40	D. A. Jobes: Summary and Outlook
12.00	Lunch

End of Conference

Afternoon: Excursion: Details see separate announcement in the abstract book.

ABSTRACTS

PLENARY SESSIONS

EARLY BIRD SESSIONS

MONDAY, MARCH 21, 2011

PLENARY SESSIONS

Video-recorded Case Interview I

Mrs A.B., aged 33, married, 1 child, office employee, certified accountant
Suicide attempt (overdose), Posttraumatic Stress Disorder, Depressive Episode (BDI: 21)
Total duration of interview 49 minutes, shown 14 minutes
Discussants: M. Schechter, D.A. Jobes

Questions to the discussants and the audience:

- What is your evaluation of the patient's story?
- In which way is it typical/untypical for attempted suicide?
- What therapeutic interventions would you recommend with this patient?

U. Schnyder, M.D.: The Experience of Trauma in PTSD

The typical symptoms of re-experiencing in posttraumatic stress disorder (PTSD) include intrusive and distressing recollections, and recurrent distressing dreams of the traumatic event, i.e., nightmares. Intrusive memories can become so real that patients start acting or feeling as if the traumatic event were actually recurring. These dissociative states or flashback episodes are phenomenologically similar to what has been described in patients immediately prior to attempting suicide. Behavioral manifestations associated with re-experiencing can be referred to as fight, flight, or freeze modes of stress reactions, respectively. Emotions of fear, anger, guilt, and/or shame connected to dissociative episodes are frequently not only related to the index trauma that had precipitated PTSD, but also to other adverse events which patients experienced in childhood or adolescence. During and shortly after dissociation, patients frequently report perceiving their "continuity of the self" as disrupted. Trauma-focused psychotherapy requires the patient to adequately regulate their emotions, and to be familiar with anti-dissociative techniques.

M.D. Rudd, Ph.D.: Dissociation and the Suicidal Mode

The basic tenets of the suicidal mode will be reviewed, with a particular focus on the dissociative mode and its role in relationship to trauma and those struggling with post-traumatic stress disorder. The role of various components of the mode, including the cognitive, affective, physiological subsystems will be reviewed, emphasizing clinical intervention and treatment. A case example will be provided to fully illustrate the dissociative mode in clinical context.

Evening Session in Memoriam Israel Orbach
I. Weinberg, L. Firestone: Suicide and Trauma, Dissociation, and Mental Pain

I. Weinberg will review Israel Orbach's life story and give a general overview of his major contribution to the suicide literature, including (1) suicide in children and its dynamics, (2) perception of death, its development, and suicidal tendencies (3) suicidal body: pain perception, body experience, and touch perception (4) research on mental pain, (5) empathy to suicidal wish: treatment approach. Being his student since 1991, I will share personal memories. In addition to being a prolific and creative researcher, he was also an inspiring teacher, revered by his students. A few lucky ones were advised by him for research and benefited from breadth of his knowledge and clinical acumen. His uncompromised search for emotional connection with people led to his humane clinical approach to treatment and focus on emotional pain.

L. Firestone will present and comment excerpts of a video-recorded interview with Israel Orbach.

TUESDAY, MARCH 22, 2011

EARLY BIRD SESSIONS

G.K. Brown, Ph.D: Safety Planning: A Brief Intervention to Mitigate Suicide Risk

Objectives: (1) to describe the background and rationale for safety planning as a brief intervention for use with suicidal patients in acute care settings such as emergency departments, inpatient units and crisis hotlines, (2) to teach participants how to conduct safety planning using a systematic step-by-step approach, and (3) to provide an update of recent studies that are underway to evaluate the effectiveness of this approach.

The intent of safety planning is to help individuals lower their risk for suicidal behavior by consulting a pre-determined set of potential coping strategies and list of individuals or agencies that may be contacted. Safety planning, as conducted in VA settings, has recently been recognized by the SPRC and AFSP in the Best Practice Registry for Suicide Prevention.

The Safety Plan consists of a hierarchically-arranged list of coping strategies identified for use during a suicidal crisis or when suicidal urges emerge. The specific intervention components include: (1) Identifying the warning signs, (2) Internal coping strategies that require patients to distract themselves from their suicidal thoughts, (3) External coping strategies that require contacting another person or going to a safe social setting without disclosing suicidal thoughts, (4) Asking Individuals for help with the crisis, (5) Asking professionals or agencies ask for help, and (6) Making the environment safe.

R. Young, Ed.D., L. Valach, Ph.D.: Trauma Narratives

In order to address the main topic of the conference, that is, the usefulness of the trauma concept for understanding suicide, this session will discuss some cases and illuminate the traumatic experience in childhood as a background of a suicide action using video recordings of suicide narratives.

The suicide process as well as the processes involved in trauma and PTSD symptoms have been discussed from different views, stressing, on the one hand, the impulsive, emotional, uncontrolled, unconscious, stimulus driven and, on the other, the task and goal oriented conscious behaviour as well as combination of thereof, such as goal oriented unconscious behaviour.

As the concepts of emotional, conscious or impulsive behaviour are terms indicating certain quality in behaviour but do not provide a comprehensive conceptualization of ongoing processes, we suggest turning to system action concepts.

Within the action theory based conceptualization, we proposed that suicide is a goal directed process in actions, projects and a suicide career. Although the conscious goals, subconscious control processes and unconscious regulation occur all at the same time, this model has some proximity to „top down steering“. We further suggested, that, while suicide as well as the life facilitating processes are goal directed, some of suicide narratives indicate a „bottom up steering“ in the connection of these two systems – life facilitating and suicide processes.

In the session we will provide narratives after a suicide attempt in which the role of childhood trauma in the suicide career is indicated. We will describe different types of traumatization as well as their different connections to the suicide processes. Using video recording and transcripts we will discuss the fit and usefulness of this conceptualization for the understanding of trauma in relation to suicide. This presentation will be particularly useful for practitioners.

PLENARY SESSIONS

K. van Heeringen, M.D., Ph.D.: The Vulnerability Concept in Suicide Research

The vulnerability concept may help to explain the observation that some individuals develop health-related problems when confronted with particular triggers, while others may not show these problems upon exposure to the same events. In general, the presence of vulnerability is reflected by an increased reactivity to triggers, which commonly are ordinary conditions of life that are borne by the majority of individuals without problems. Vulnerability is thus commonly conceptualized as a predispositional factor, or set of factors, that makes possible a disordered state.

Studies of the aetiology of suicidal behaviour have shown an important role of such predisposing distal risk factors, i.e. characteristics that increase the risk upon confrontation with triggering life events. Such characteristics may include a familial history of suicidal behaviour or cognitive psychological features. Sociologists, biologists and psychologists have tried to define the vulnerability to suicidal behaviour and develop models of suicidal behaviour. Examples of such models include the ‘cry of pain’ model and the monoaminergic hypothesis of suicidal behaviour. Recent developments in neuroscience provide intriguing opportunities to integrate such divergent approaches, so that insight in the causes of suicidal behaviour is increasing.

The potential importance of the vulnerability concept for the prevention of suicide is related to the fact that vulnerability persists, and thus may be demonstrated and treated between (or even preceding) suicidal crises. Many aspects of the vulnerability concept however are still unclear, and further study should target, for example, its dichotomous or continuous nature, and the extent to which vulnerability is amenable to change.

M. Bostwick, M.D.: Adverse Childhood Experience and Susceptibility to Suicidal States

The neurobiological effects of childhood abuse and neglect manifest in affective, somatic, behavioral, cognitive, relational, and intrapsychic sequelae. Altered brain organization resulting from repetitive early trauma expresses itself in distortions in an individual's self-understanding and world-view. Contemporary behavior reflects childhood experience, with compromised attachment behavior, impulse control, and emotion modulation playing out not only in day-to-day life but also in the therapeutic relationship. This presentation will focus on the nature of the adverse experiences that can precipitate such wide-ranging and devastating effects and how they can become hard-wired, resulting in heightened susceptibility to suicidal states.

J. T. Maltsberger, M.D.: The Traumatic Experience of Intolerable Affective States

Unrelieved and intense states of subjective suffering can be intolerable. Patients suffering mental anguish of this order become desperate, and, helpless to escape it, may attempt suicide to get out of the emotional trap where they are caught. Overwhelming mental anguish of this order is in itself traumatic and cumulative in effect. Repeated episodes of traumatic affective overarousal diminish the capacity to maintain hope, and erode the ability to sustain relationships to others that are ordinarily life-protective. Repeated and continued affective traumatization undermines mental organization and invites psychotic and suicidal breakup.

Video-recorded case interview II

Mrs. N.F., aged 27, married 2008, twins born 2008
Overdose with Lithium (blood level at 4 hrs 3.66 mmol/L)
Recurrent Depression, Posttraumatic Stress Disorder, Borderline Personality Disorder
First suicidal crisis 2001, followed by psychiatric inpatient care for most of the time over 2 years (15 admissions), followed by many more hospital admission. Repeated episodes of self-harm (cutting, burning). Several serious suicide attempts.

Total duration of interview 34 minutes, shown 18 minutes

Discussants: M. Goldblatt, A. McQuillan,

Questions to the discussants and the audience:

- What is your evaluation of the patient’s story?
- In which way is it typical/untypical for attempted suicide?
- What therapeutic interventions would you recommend with this patient?

WEDNESDAY, MARCH 23, 2011

EARLY BIRD SESSIONS

L. Firestone, Ph.D.: Trauma and the Critical Inner Voice

The key to understanding suicide and self-destructive behavior comes from the awareness of the destructive thought processes that control such behaviors. Being cognizant of how self-critical thoughts can lead to a self-destructive downward spiral enables clinicians to better assess risk and design interventions for depressed and suicidal clients. Part of the individual wants to live; part wants to die. But it's the part that wants to die that is in control at this moment. This part is governed by a negative thought process that colors the perception of self, others, and life in general. Understanding this fundamental ambivalence and the associated destructive thought processes is key to assessing risk and intervening effectively in suicidal crises.

S. Kupferschmid, M.D.: The Destiny of Kronprinz Rudolf II. (1858-1889): Parental Effects on Development and Epigenetics from the Perspective of a Historic Suicide

Rudolf (1858–1889), archduke of Austria and crown prince of Austria, Hungary and Bohemia, was the son and heir of Franz Joseph I., emperor of Austria and his wife and empress, Elisabeth. His death, apparently through suicide, at his Mayerling hunting lodge in 1889 made international headlines, fueled international conspiracy theories and ultimately may have sealed the long-term fate of the Habsburg monarchy.

In his biography, several stress factors can be identified: high expectations of the parents lead to early burdensome duties and an educational style focused on military discipline. He was brought up by changing attachment figures The mother, Empress Elisabeth, was absent due to mental problems over a longer period of time.

Based on this historical case report, the impact of early traumatization due to parenting style is summarized. Special attention is being paid to parental mental health problems as a risk factor for the development of a child. The risk of children to develop a psychiatric disorder is raised by factor 3–4 if one parent is mentally ill.

In light of this, results from the BESTEKKE–Study (Bernese study on the influence of parental mental disorder on the development of their children) are discussed. In this study we conducted a comprehensive survey of patients treated because of mental health problems in the University Hospital of Psychiatry, Berne, Switzerland.

I. Weinberg, Ph.D.: Traumatic and Suicidal States: Examination of the Relationship

This presentation compares traumatic and suicidal states. These states are similar in terms of experience of emotional pain and its structure, hopelessness, dissociation, time experience, cognitive deconstruction, nightmares, presence of psychotic features. A number of hypotheses (repetition of trauma in suicidal states, similar response to intolerable stress/affect, similar vulnerability to suicide vs. trauma) to explain this similarity will be discussed and compared in terms of empirical and clinical findings. Clinical examples will be provided. Treatment implications will be discussed.

PLENARY SESSIONS

A. McQuillan, M.D.: Borderline Personality Disorder and Trauma

Traumatic experience is recognised as an important aetiological factor in Borderline Personality Disorder (BPD). These experiences usually occur during childhood and adolescence, and range from emotional abuse and neglect to physical and sexual violence.

The impact of trauma on young people in a key phase of their development accounts for the long-lasting and pervasive effects on cognition, emotions and behaviour. Most importantly it produces emotional or affective instability, which is not only a core feature of BPD, but is also strongly linked to suicidal behaviour, itself another core feature of BPD. Whilst some people suffering from BPD also meet criteria for post-traumatic stress disorder (PTSD), the majority of patients with BPD who have experienced past trauma do not. Thus for many patients, particularly adolescents, the clinical consequences of their trauma is not well captured by current diagnostic tools.

This presentation will cover the role of trauma in the development of BPD including biological underpinnings, and its implication for treatment.

H. Hjelmeland, Ph.D.: Do We Have the Right Research? Some Reflections on the Best Way Forward

During the last decades suicidological research has been dominated by epidemiological studies focussing on psychological and/or social risk factors. Currently, the focus on (neuro)biological research seems to be on the increase, and, there are calls for more treatment/intervention research, particularly in the form of randomised controlled trials (RCT-studies). Behind most of this research there is a simplistic linear cause-and-effect thinking based on the biomedical illness model. However, people are complex, reflective beings, and suicide is by definition a conscious, *intentional* act. Thus, although such research can provide important contributions to a basis, it will not get us all the way in terms of *understanding* suicidal behaviour or suicidal people. We therefore need some "new" thinking both theoretically and methodologically. We need to move away for the almost exclusive focus on quantitative large-sample research. That is, we need more qualitative research. We also need research that explicitly takes the socio-cultural context of suicidal persons into consideration in the analysis of (all kinds of) data. And, we need truly multidisciplinary research where psychiatrists, psychologists, sociologists, anthropologists, etc., work together so that interactions between biological, psychological, social and cultural factors can be studied.

Panel discussion: Does the Trauma Concept Get Us Further in Suicide Research?
D.A. Jobes, M.D. Rudd, T. Lineberry, K. van Heeringen, A. McQuillan

D. A. Jobes: Summary and Outlook

This final plenary presentation of the conference will pull together the findings and highlights of the conference and its unique consideration of trauma and suicidal behavior. A larger consideration of the "Aeschi approach" in relation to trauma and suicide will be explored in reference to case example illustrations of key points. The plenary will conclude with a review of the Aeschi movement—past, present, and future. In the course of this review, there will be full consideration of what we think we know and possible next steps in clinical suicide prevention. The critical importance of maintaining clinical vitality in the face of daunting clinical work with suicidal patients will be emphasized.

ABSTRACTS

WORKSHOPS

MONDAY, MARCH 21, 2011

M. Goldblatt, J.T. Maltsberger, E. Ronningstam, M. Schechter: Trauma and Suicide Clinical Case Discussion: The Case of Peter F. Part 1 and Part 2

Traumatic experiences in childhood, including sexual and physical abuse, commonly produce post-traumatic stress disorder (PTSD) in surviving adults, and are associated with an increased rate of suicide. The experience of the trauma reduces the patient's ability to adequately maintain affect regulation and endure emotional suffering, often resulting in breakdown of the self. The subjective experience of patients who experience their own suicidal crisis is similarly affectively overwhelming. We suggest that a suicide attempt is an assault on the self and constitutes a psychic trauma, which is an accumulation of over-excitation, experienced as affect overload. Repeated suicide attempts are destructive on many levels; they corrodes the ability to form and keep attachments to others, they erode the patient's capacity to endure intense affective states, and diminish hope through an attrition of higher level coping mechanisms.

In this workshop we present the case of a man who died by suicide while in treatment. We take up three aspects of this case: childhood trauma and the development of coping strategies that lead to suicide vulnerability; trauma as an internal subjective experience that effects self-regulation and increases risk of suicide; and clarification of the differences between a true therapeutic alliance and the experience of mutual positive regard.

D.A. Jobes, M. Ghahramanlou Holloway, M.D. Rudd: Combat Related Trauma and Suicide: Concepts of Therapy

Since the terrorist attacks of 9/11 on New York and Washington DC, the United States Armed Forces have been engaged in combat for almost ten straight years. The wars in Afghanistan and Iraq respectively referred to as "Operation Enduring Freedom" (OEF) and "Operation Iraqi Freedom" (OIF) has put a tremendous level of stress on an all-volunteer military. Throughout the history of US warfare, suicide rates among active duty military personnel were always lower than matched civilian cohorts, particularly among those engaged in combat. In recent years, however, the suicide rates among Army and Marine Corp infantry have reached all time record highs. Many conjecture that the rates are due to the impact of multiple combat deployments and the general impact of war, PTSD, and TBI on troops and their families. The presenters of this workshop are each engaged in clinical treatment research programs with active duty suicidal soldiers. This workshop will thus provide perspectives of combat-related trauma, current suicidal struggles among contemporary combatants, and innovative treatments designed to effectively treat suicide risk within this population. Various case examples and features of new treatment will be presented to illustrate these new clinical approaches to a most challenging problem.

K. Michel, A. Malafosse: Genetic and Neurobiological Aspects

In this workshop we present an integrative overview of the complex interplay of genetic and neurobiological vulnerability with personality traits, personal and psychiatric history. There will be an overview of neurotransmitter binding studies as well as neuroimaging studies of the suicidal brain. It will be argued that the mental condition of the suicidal person is largely determined by a stress response of the organism to an – internally – threatening situation. Factors determining vulnerability include gene x environment interaction throughout the developmental years, i.e. epigenetic mechanisms. Topics to be discussed will include the role of the HPA axis and emotion regulation, suicide and neurotransmitter metabolism, the role of impulsivity and aggression in suicide, impairments of problem-solving. It will also be argued that the suicidal mode, which includes alterations in emotion, cognition, physiology, and behaviour is a state of mind which may have the characteristics of a traumatic condition. The discussion will particularly focus on the individual and therapy-oriented implications of a neurobiological model of suicide.

D. Jobes: SSF/CAMS Update and Feedback Session

The use of the "Suicide Status Form" (SSF) and the "Collaborative Assessment and Management of Suicidality" (CAMS) has been featured at previous Aeschi conferences. With its emphasis on non-judgmental collaboration, clinical alliance enhancement, and qualitative assessments of the patient's suicidality the use of the SSF and CAMS is consistent with many of the core tenants of the so called "Aeschi approach" to clinical work with suicidal patients. Since the initial development of the SSF and the later use of the SSF within CAMS, a steady stream of clinical research in real-world settings has further evolved the approach increasing both its clinical utility and empirical support. In recent years the Catholic University Suicide Prevention Research Laboratory has pursued various feasibility studies and clinical trials of CAMS in a range of settings. This workshop will provide both an overview to the SSF/CAMS approach and provide an update on recent innovations in clinical practice and empirical research. Adaptations of SSF/CAMS for use within European clinics will be presented and general discussion of the approach and next steps will be explored

TUESDAY, MARCH 22, 2011

A. Andreoli: Traumatic Mourning Focused Psychoanalytic Psychotherapy (TMFPP) among acutely suicidal borderline patients: clinical potential and treatment technique

The purpose of this workshop is to introduce a new psychodynamic model for cost-effective intervention among acutely suicidal borderline patients. Simple interventions do not work much among suicidal patients with concurrent borderline personality disorder and specialized strategies adapted to treat borderline patients were not studied in general populations referred to community services at emergency room discharge. To implement cost-effective treatment strategies well adapted to treat borderline patients referred to general psychiatric services in a suicidal crisis is an important mental health target requiring more research. According to this point we will discuss the rationale and results of a new psychodynamic intervention for acute treatment among borderline patients referred to

emergency room with suicide attempt. Traumatic Mourning Focused Psychoanalytic Psychotherapy (TMFPP) was targeted to treat acute stress disorder and pathological mourning process consecutive to traumatic abandonment, a common clinical correlate of suicidal crisis among borderline subjects. Based upon previous studies, we assumed that a specific focus of psychotherapy should be to convey more attention on patient maladaptive sentimental life, and its roots in vicious circle of present traumatic interpersonal conflicts and past adverse experiences of neglect and abuse. To work-out the underlying pathological idealization process, inadequate attachment schemas and paradoxical identifications is considered, together with warm support, active confrontation and setting limits, active ingredients of this method. Then we will resume the results of several studies showing that well structured 3-month TMFPP is superior to usual good quality treatment at lower costs among these patients.

M. David Rudd: Cognitive Behavior Therapy for Suicidality (based on a clinical case)

The workshop will provide an overview of cognitive behavior therapy for suicidality, including suicidal ideation and suicide attempts. A brief treatment model will be emphasized, including conceptualizing treatment phases, rather than distinct session by session goals. This provides the clinician with greater flexibility in the treatment process given the broad range of patient skill levels when entering treatment. The goals for each treatment phase will be reviewed, with a case example providing clinical context. Specific and simple clinical interventions will be discussed in detail including: the conceptual model that drives the treatment process, collaborative treatment agreements, crisis management and safety planning, means restriction, monitoring treatment progress, self-management skills, managing homework, the role of social support, along with a few additional targeted skills.

H. Hjelmeland, B. Knizek: Qualitative Research in Suicidology: Challenges and Opportunities

Qualitative studies are few and far between in suicidology, at least judged by the proportions of publications in suicidological journals (Hjelmeland & Knizek, 2010). We argue that the suicidological field needs more qualitative research that takes into consideration the dynamics in the relationship between the individual and his/her specific socio-cultural context. It will also contribute to the understanding of the suicidal process. This workshop will focus on the challenges and opportunities faced in the endeavour towards increasing qualitative suicidological research by 1) taking a brief look at what has been done in terms of qualitative research in the suicidological field so far, 2) discussing what kind of knowledge practitioners need in their work with suicidal patients and how qualitative research can contribute to get that knowledge, and, 3) discuss *how* we can deal with some of the challenges (e.g., negative attitudes and even prejudice towards qualitative research among journal editors, reviewers and funding sources).

A. Beautrais, P. Wong, T. Vila, A. Habenstein, A. Maillart, K. Michel: Attempted Suicide: Should Therapeutic Interventions Start Right in the Emergency Room?

The emergency department is an increasingly important site for suicidal patients to have contact with the healthcare system. Suicidal patients have high near-term risks of suicide and suicide attempts after leaving the Emergency Department. For many, the ED functions as their de facto healthcare provider – creating new opportunities for surveillance, screening, brief interventions, and referral.

ED suicidal patients are frequently not adherent with traditional mental health interventions. There are increasing pressures on EDs to decompress and link patients into outpatient treatment, but cost-effective ED-initiated interventions to improve outpatient care transitions and symptom/ illness self-management are lacking. There are few effective ED interventions for suicidal patients; none have assessed cost-effectiveness.

The ED is an untapped setting for developing cost-effective approaches to screening, establishing suicide registers, developing brief interventions, promoting referrals, enhancing engagement, and ensuring follow-up. With optimal staffing and resources, multidisciplinary ED teams consisting of professionals from emergency medicine, psychiatry, psychology, toxicology, social work, police, nursing, and related areas could partner with innovators and suicide researchers to leverage the ED as a suicide prevention site. Careful staff selection and continuing staff education about suicide, and improved data surveillance about suicide-related presentations, underpin ED-based suicide prevention activities and are also needed.

In this workshop we shall discuss the actual situation in EDs in different locations, such as Hong Kong and Bern, and the possibilities of improvement.

POSTERS

Suicide Risk Assessment with PRISM-S – Simple, Fast and Visual

Mariann Ring, Gregor Harbauer, Sebastian Haas
Integrierte Psychiatrie Winterthur ipw, Winterthur, Switzerland

A variety of measures are already available to assess 'suicidality'. However, they are generally too complex and too time-consuming for use in routine clinical practice. Furthermore, in most cases, the validity of these assessments relies heavily on patient's language skills.

PRISM - the Pictorial Representation of Illness and Self Measure is a visualization technique that was initially developed to evaluate 'the perceived burden of suffering due to physical illness'. The PRISM proved to take less than five minutes to complete and is unusual in relying only minimally on language. It is easy to apply and it revealed to be a simple tool to facilitate clinician-patient communication.

In our pilot study (2008) we adapted the PRISM task in order to measure the subjectively perceived 'suicidality' (PRISM-S) of patients who were admitted to the inpatient crisis intervention centre Winterthur. The results of the pilot study revealed a good performance and showed promise in its contribution to suicide risk assessment.

First results of our ongoing study of PRISM-S (start November 2010) will be available and presented.

Suicidal Adolescents' Subjective Perception of their Social Network And its Potential Support Value

Bertrand Auckenthaler
Centre d'Étude et de Prévention du Suicide, Genève, Switzerland

Social isolation or feeling of detachment are common symptoms associated with suicidal ideation as well as trauma related disorders. It remains unclear though if lack of perceived social support is a triggering factor or a consequence of suicidal ideation. Clinical experience and research have shown the reluctance of help seeking in suicidal patients and hence the importance of collaborating with their social network, as it has been shown for PTSD.

In adolescence, as the social network (especially peer network) gains quantitative and qualitative importance, it is essential to better understand adolescents' network composition and how it is perceived during suicidal crisis.

Objective: This explorative research aims to investigate perceived social network in suicidal adolescents, measuring its supportive as conflicting value.

Method: Pilot study collecting data from 10 suicidal adolescents of a psychiatric outpatient crisis unit and 10 control adolescents, using self-report questionnaires and a sociometric questionnaire, *Family Network Method*, for quantitative and qualitative evaluation of the network subjective perception.

Research hypothesis: Suicidal adolescents' subjective social network is expected to be quantitatively restrained, with more peers than relatives, qualitatively more conflicting, influencing and less supportive, especially in family context. Parents would furthermore have an enhanced paradoxical role of support provider and source of conflict.

Chances And Limits of Method Restriction: A Detailed Analysis of Suicide Methods in Switzerland

Astrid Habenstein[1], Timur Steffen[1], Stefan Kupferschmid[2], Thomas Reisch[1]
1) University Hospital of Psychiatry Bern, Switzerland
2) University Hospital of Child and Adolescent Psychiatry, Bern, Switzerland

Objective: Switzerland has the fourth highest suicide rate in Western Europe. Method restriction is one of the few evidence based suicide prevention methods. Our objective was to estimate the potential of method restriction as a suicide prevention strategy for Switzerland.

Method: Data from the Swiss Federal Statistical Office and the Swiss Institutes of Forensic Medicine from 2004 were gathered to gain detailed information about suicide methods. Merged data was categorized into submethods according to accessibility to restriction of means.

Results: According to FSO, 27.2% of the total suicides were carried out by hanging, 23.6% were committed by firearms, 12.6% died by fall from heights and 11.9% by intoxication with drugs.

A total of 39.2% of suicides in Switzerland are accessible to method restriction. The highest proportions were found in private weapons (13.2%), army weapons (10.4%), and jump from high places at hot-spots (4.6%), followed by hanging in institutions (4.0%), suicides by lethal substances (tricyclics, barbiturates, paracetamol, 3.8%), and railway suicides at hotspots (2.5%).

Conclusion and discussion: The presented method permits the estimation of the suicide prevention potential of a country by method restriction, and to compare the restriction potentials between suicide methods. In Switzerland, reduction of firearm suicides has the highest potential to reduce the total number of suicides. Restriction of means can only be applied to less than half of the suicides in Switzerland and must therefore be supplemented by other suicide prevention activities.

Influence of the Introduction of the Swiss “Army XXI” on the Suicide Rate.

Thomas Reisch, Timur Steffen. Astrid Habenstein
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Introduction: Switzerland has a very high number of suicides by shooting compared to the rest of Europe. One reason can be found in the Swiss army. Due to historic reasons, any soldier has to store the gun at home until the end of the military service, even when not being active. At the end of the service any men can keep the weapon for a minimal fee. Such weapons are usually stored at home. In 2003, the Swiss army was reformed and modernized (“Army XXI”). The number of active soldiers and the rate of men who kept the gun at home was significantly reduced as a result of several changes.

Method: We investigated the influence of theses changes on the method specific and general suicide rate using the method of interrupted time series.

Results: We found a decrease in the suicide rate by guns in the method specific rate and the total suicide rate after the introduction of the Army XXI, this was true in the affected age group, but not in other age groups.

Conclusion: Restriction of means led to the reduction in the overall suicide rate in the affected age group.

Tracking the Suicidal Process with The Synergetic Navigation System

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Current suicide models are almost exclusively linear, characterized as simple input-output models. This may explain why, despite decades of research, the prediction of suicidal behavior remains highly limited. In the suicidology literature, there are repeated recommendations for using nonlinear models that will reflect the complexity and dynamic nature of the suicidal process. However, related technical applications that could be used in routine clinical practice have been lacking. We present the Synergetic Navigation System (SNS) as a web-based tool that can tract the suicidal process and analyze it nonlinearly, thus expanding research possibilities. Most importantly, the SNS is to be used interactively, i.e., patients regularly discuss the results with the therapist, with both likely profiting from insights into the process. SNS can therefore serve as additional tool to "meet the suicidal person".

Patterns in and Predictors of Swiss Suicide Rates, 1951-2006

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Data on suicide rates in Switzerland for males and females aged 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75 and older are analyzed for the 1951-2006 time period. The data analysis has two objectives: (1) To examine the trends in Swiss suicide rates over time for each age/sex group separately; (2) To identify social and psychological variables that are related to the suicide rates. The social and psychological variables that are used in this study include fertility rates, alcohol consumption, and economic growth. Results find that both (1) patterns in the trends over time and (2) the factors that predict suicide rates are different for males and females. A social-psychological theory of Swiss suicide, based on Durkheim's theory of Social Integration, is developed based on the results of this analysis.

Modeling the Course of Depressive-Suicidality Following Suicidal Crises

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Suicide risk factors (depression, hopelessness, suicide ideation/intent) are often conceptualized as discrete variables, potentially engendering unnecessary or misleading reductionism. Arguably, most individuals experience a multifaceted combination of these, likely preceding escalation into crisis and lingering after in a complex manner. This common depressive-suicidality (DS) could be approached statistically as the aggregate/shared variance among common suicide risk factors. In the current study, a latent growth model (LGM) was used to extract DS variance from the BDI, MSSI and SPS. 331 young, (mostly) male adult consecutive referrals to emergency services for a suicidal crisis were followed in a controlled trial for 2 years. LGM estimated a trajectory of DS from baseline through 6-month follow up, plotting the average course of DS. This model represented a good fit, and was expanded to include effects of past suicide attempt, mood disorder, and baseline levels of agitation (anxiety v. hypomania). High anxiety at baseline (intercept) was associated with a heightened DS crisis, but also with rapid reduction of DS over time (negative effect on slope). A mood

disorder similarly heightened the baseline DS crisis, but was associated with rapid reduction of DS over time. Prior suicide attempt was associated with increased severity of the incident DS crisis, but had no effect on subsequent course. In contrast, high hypomania at baseline preserved or prolonged the DS crisis without influencing DS severity at baseline. Further research is needed to verify and conceptualize these findings, as well as to advance use of complex statistical models in suicide research.

Resolution of Suicidality: SSF II-R Used in a Danish Outpatient Feasibility Study

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The centers of suicide prevention in Copenhagen and Risskov are 2 regional outpatient mental health services (clinics) providing assessment, counseling and short-term treatment to patients with burdensome suicide thoughts and / or attempts.

The treatment model in both centers represents a close adherence to the CAMS framework of which SSF II-R is the core part: active engagement of patients in collaborative assessment and management of suicidality:

- use of SSF II-R information to generate a suicide-specific treatment plan that explicitly and directly targets all suicide-relevant issues
- systematic resolution of suicide risk through safety plans and finding alternative solutions to the problems that drive suicidality.

In this study, some of the questions we wanted to look at were: usefulness of SSF II-R in a sample of Danish outpatient suicidal patients, overall effect of treatment as measured on the 5 Likert scales, potential differences between various demographic groups and effect, possible correlations between baseline scores (fist session) and number of sessions.

Conclusions: The reduction of scores on the 5 Likert scales indicates a very strong and positive outcome with regard to reduction of suicide risk at the end of treatment. The pre-post design of the present study, however, limits our chances to establish firm conclusions about the possible causes of this outcome. Special clinical attention to therapeutic methods that aim at reducing agitation seems to be indicated in the future. The Danish translation of the SSF II-R is a useful clinical tool in the naturalistic clinical setting of regional suicide prevention centers with a heterogeneous population, rapid turn-overs and high caseloads.

Understanding Aborted Suicide Attempts: A Mixed-Methods Approach

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About 1000 people die by suicide in Hong Kong annually. The number of attempted suicides is estimated to be up to 10 to 40 times higher. Previous suicide research conducted in Hong Kong mainly focused on completed suicides. Initiatives that mainly target people with risk factors for completed suicide seem not to be comprehensive. Thus, more studies about attempters are urgently needed in Hong Kong.

The essential characteristics of an aborted attempt include 1) an intent to kill oneself, 2) a change of mind immediately before the actual attempt, and 3) an absence of serious injury.

Studying aborted suicide attempts has an advantage of knowing the actual thoughts and actions that have stopped these individuals for implementing their plans.

This study will provide important data on the cross-cultural generalizability of established theories of suicide attempt based primarily on Western data and provide guiding information on the future development of evidence-based crisis intervention.

Attempted Suicide Short Intervention Project (ASSIP) - Progress Report

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The Attempted Suicide Short Intervention Program (ASSIP) consists of usually 4 sessions with the following elements: (1) a narrative interview aimed at an understanding of how patients explain suicidal crisis in the context of their personal history, using an action theoretical model of suicidal behaviour, (2) video-playback and reconstruction of the patients' narrative, identification of the main biographical issues related to the suicide attempt, (3) a collaborative development of personalized coping skills, summarized in writing and handed out to patient and therapist (4) standardized letters over time span of two years. The control group receives one clinical interview aimed at evaluating suicide risk. Both groups are followed up over two years. Currently, we have 106 patients included in the study, 56 in the ASSIP, and 43 in the control group. This poster lists some of the difficulties we encountered in the course of this clinical study with a 2-year follow-up. Other clinical researchers have reported similar problems with the follow-up of suicidal patients. We conclude that follow-up studies need an active and personalized „outreach" contact, and that it may be difficult to keep study and control groups „pure".

Attempted Suicide Short Intervention Project (ASSIP) – Some Preliminary Results

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For the description of the interventions used for our Attempted Suicide Short Intervention Program see the abstract above. We are now getting first results from the initial interviews and the follow-up of the ASSIP (currently N=56) and the control group (currently N=43). In the first interview we did not find a significant difference in the Helping Alliance Questionnaire (HAQ) between ASSIP and the control group. However, there is an increase of the HAQ score between session one and three in the ASSIP group. For follow-up both groups are asked to fill in a set of questionnaires over a follow-up period of 2 years (t1 – t5) with the following measures: Psychosocial variables, health service contacts, suicide attempts and self-harm, Beck Suicide Ideation Scale, Beck Depression Inventory, SSF-II, SCL-9, COPE. At t2 (three months) we found that ASSIP subjects had lower scores in the SCL-9 and the BDI compared to the control group, and an increase in coping strategies. We interpret these preliminary results that therapeutic alliance, which is a central focus of ASSIP, may be a protective variable for patients after attempted suicide.

Suicidal Behavior in a Sample of Street Prostitutes

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Although few international studies correlate suicidal behavior and prostitution, the literature shows several risk factors for suicidal behavior in prostitutes, mainly in those that work on the streets. Thus, we intend to address the incidence of suicidal behavior in a sample of street prostitutes and correlate it with some other data, such as perceived social support and their level of victimization.

The aim of this presentation is to show some results of a study carried out in Porto (Portugal), in which 52 street prostitutes were interviewed. For data collection we applied the Suicide Ideation Questionnaire (QIS) and the Scale of Social Support Satisfaction (ESSS).

Among other results, we obtained an average of 41.71 points on the QIS with a standard deviation of 29.92 points, these values indicate a high risk of suicide. Moreover, 46.15% of these women reported higher than 41 points in the QIS, which represents a value significantly higher. Regarding the perception of social support, we found a statistically significant correlation with the level of suicidal ideation.

The results allow us to infer that suicidal ideation in this sample is considerably higher than the general population, and also that there is a higher prevalence of suicide attempts.

Prescription Medications and Increased Suicide Risk

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Multiple prescription medications have been reportedly associated with suicidality, and there is increasing interest in understanding these clinical relationships. Unfortunately, the current literature is limited, and much of the supporting evidence is anecdotal, based on clinical reports, or confusing. We conducted a literature search to identify evidence of increased suicidality related to specific prescription medications or medication classes with the goal of developing a clinically useful reference. For each medication or medication class, we evaluated the supporting evidence using a modified American Association of Family Practice method for *ABC* grading of evidence.

We considered whether a plausible mechanism for increasing suicidality had been described, and whether relevant black box warnings had been published by the United States Food and Drug Administration. *Naranjo and colleagues'* algorithm for evaluating the likelihood of adverse drug reactions was modified and applied to each medication to determine the likelihood suicidality was an adverse effect of the medication. Our initial survey identified increased suicidality for medications including rimonabant, interferon a, selective serotonin reuptake inhibitors, selective serotonin norepinephrine reuptake inhibitors, varenicline, isotretinoin, and reserpine. The work is significantly limited by the difficulties of identifying a complex multifactorial adverse effect such as suicidal behavior, as it requires controlling for many variables, including pre-existing psychiatric illness, age differences, gender, and the prevalence of a behavior in populations receiving different levels of care. Our work will continue to encompass more medications and evaluative approaches, and will hopefully become a comprehensive and clinically useful resource for clinicians.