Konrad Michel · Anja Gysin-Maillart

ASSIP

Attempted Suicide Short Intervention Program

A Manual for Clinicians

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ASSIP – Attempted Suicide Short Intervention Program

About the Authors

Konrad Michel, MD, is a clinical psychiatrist and psychotherapist who has developed a model of understanding suicidal behavior based on the theory of goal-directed action and narrative interviewing. He is the initiator of the Aeschi Working Group – an international group of clinicians and researchers dedicated to improving clinical suicide prevention by developing and promoting patient-oriented models of understanding suicidal behavior.

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Preface

People with a history of suicidal behavior have their own individual stories, and so does this manual. The story started with the cooperation between me (K.M.), a psychiatrist who had undergone traditional medical training, and my friend Ladislav Valach, a qualified psychologist with a special interest in social psychology and, in particular, in what is called *action theory.* It was not until much later that I realized how much these two backgrounds in professional training differ in their "image of man" (*Menschenbild*), and how fruitful such an interdisciplinary collaboration could be.

Just as in the narratives of suicidal individuals, the story of this manual starts much earlier. It began during my training in the United Kingdom: On a morning when I arrived at the hospital and was told by the nurses that one of my patients, a 42-year-old woman with a husband and two preschool children, had just thrown herself under a truck. This experience had far-reaching consequences for me – not unusual for a young psychiatry resident. I started to read about clinical suicide prevention, and when I returned to Switzerland, I began a study of the clinical risk factors and the role of health professionals in dealing with suicidal patients. The question of what clinicians can do better to reduce the number of suicides has been an important part of my professional life ever since.

But let's return to my colleague, Ladislav Valach. During a coffee break, he made a provocative remark, which turned out to have long-term consequences: "Suicide and suicide attempts are not illnesses, but actions. You medical people have learned to understand conditions in terms of signs and symptoms – i.e., pathology – and make a diagnosis, but you have never learned to understand the nature of actions."

Despite my inner reluctance, I agreed to write a case description of a patient who, after a suicide attempt, had died by suicide 1 year later, from the perspective of action theory. The basic concept was that actions, including suicidal actions, are goal directed (e.g., to put an end to a state of mental pain), and that existential crises occur when a person is faced with a situation that is a threat to important life (or "life career") goals. In addition, action theory states that in everyday life, people use stories to explain and understand actions ("Well, this is a long story...."). As part of a study supported by the Swiss National Science Foundation, we tested the hypothesis that patients seen after a suicide attempt would feel better understood if the exploratory interview was conducted according to the concept of suicide as an action – as opposed to the traditional medical model, in which suicide is seen as a symptom of mental illness. In an action theoretical approach, the interviewer sees suicidal individuals as agents of their actions, capable of "knowing" the story behind a suicide attempt. We found that patients rated the therapeutic relationship as significantly better if the interviewer used a narrative approach (that is, opening the conversation by using the words *story* or *narrative*). This seemed to us an important insight, considering the serious communication problems between health professionals and suicidal individuals. One of the major problems in clinical suicide prevention is that patients who have attempted suicide do not comply with follow-up treatment. We hoped that with a narrative interview technique, a therapeutic relationship could be established early in treatment, which would be a starting point for an effective therapy. The key assumption was that feeling understood as an individual with one's own personal story would improve treatment motivation – one of the basic concepts underlying this manual.

To discuss the results of this qualitative study, we invited a handful of internationally recognized clinical suicide researchers to a conference in 2000. In a hotel in a mountain village of the Bernese Oberland called Aeschi, the group discussed fundamental problems in clinical suicide prevention, with the help of videotaped interviews. This experience generated so much enthusiasm that the group decided there and then to continue this type of conference and open up the discussion to others. There followed 10 years of Aeschi Conferences, which brought together some of the best clinical suicide researchers and therapists from all over the world. The so-called Aeschi Working Group published guidelines for dealing with people after a suicide attempt. In 2010 the American Psychological Association (APA), published the volume *Building a Therapeutic Alliance with the Suicidal Patient* (Michel & Jobes, 2011), which had emerged from the Aeschi philosophy. In 2013 the Aeschi conferences moved to the United States (Vail, Colorado).

During that time another fruitful collaboration was established at the Psychiatric Outpatients Department in Bern, namely with Anja Gysin-Maillart, with whom I coauthored this manual. Anja Gysin-Maillart familiarized herself with the technique of narrative interviews, and together we developed a specific brief therapy for people following a suicide attempt, which we called the Attempted Suicide Short Intervention Program (ASSIP). In recent years, we have treated well over 300 patients with this intervention program, refining, enhancing, and evaluating the therapeutic approach. It is thanks to Anja Gysin-Maillart's initiative that this manual has become a reality.

Konrad Michel
February 2015

Many years of clinical experience and scientific research form the basis of this manual. My (A. G.-M.) work has always been motivated by the view that patients need specific therapeutic steps following a suicide attempt, so that they become capable of seeing life as an option again. Over the years I was continually struck by the fact that this subject left not just me but also my colleagues baffled, if not helpless. Thanks to the prolific collaboration with Konrad Michel, my point of view started to change: Understanding suicide as an action and not a disease was a crucial factor. *Every patient has his/her own very personal and individual story, which needs to be understood.* I learned to understand suicide as a goal-oriented action with an inner logic, and I became increasingly fascinated by the collaborative process of developing, devising, and assembling the elements for a specific therapeutic intervention for people who attempted suicide. As my mentor, Konrad Michel gave me a thorough introduction to the field of suicide prevention. The regular Aeschi Conferences also played a key role. They provided an opportunity for professional and personal exchange of ideas with acknowledged experts, such as David Jobes, David Rudd, Marsha Linehan, Gregory Brown, and many others. In these very special small-scale meetings, I became familiar with concepts and models ranging from neurobiology to psychoanalysis and the latest developments in cognitive behavior therapy (CBT). The focus clearly was always on a patient-centered therapeutic approach.

The development of ASSIP took several years until we decided to start a first pilot phase to investigate its effectiveness. In this phase, the feedback from patients was of paramount importance. It was important to have our patients as experts with us, "on the team." It became increasingly clear that individuals who survive a suicide attempt need a

safe place and hence a professional person, who will concentrate, along with them, fully and empathically on their individual inner experience. Therefore, we are thankful to our patients who helped us to better understand the suicidal process, and who continued to help us refine ASSIP and optimize it.

The time had come to start a scientific evaluation of the effectiveness of ASSIP. In collaboration with the Psychology Department of Bern University, we launched proper a randomized controlled trial with 60 patients each in the treatment and in the control group. As all of the patients were followed up over a 2-year period, the study took a long time to be completed. In September 2014 we got the final results, and these were very exciting, indeed. It seems that we had made a lucky choice with the therapeutic elements included in this brief therapy of 3–4 sessions, followed by regular letters over 24 months. The study gave me an opportunity to attend conferences and psychiatric institutions around the world and present our work. We were constantly met with calls for more information and to publish the therapy manual. Step by step, this ASSIP treatment manual came into existence.

With this manual I hope we have done justice to the patients' expert knowledge, and I express my heartfelt thanks for the invaluable contribution of every person who has participated in this project.

Anja Gysin-Maillart
February 2015

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My (A. G.-M.) warmest thanks go to my husband, Tobias Gysin, for his infinite patience and constant support of my work, but especially for editing the images in the treatment section of this manual. I thank my daughters, Sophie and Mia, for all of the magic moments we share, which help me time and time again to rediscover the inspiration I need for my work.

1 Introduction

Every year more than 800,000 people die by suicide, which equates to one death every 40 seconds (World Health Organization [WHO], 2014a). The number of attempted suicides is 10 to 20 times higher. After attempted suicide, the risk of a completed suicide is elevated 40 to over a 100 times compared with that in the general population (Harris & Barraclough, 1997; Hawton et al., 2003; Owens, Horrocks, & House, 2002). It is highest in the first 2 years (Suokas, Suominen, Isometsä, Ostamo, & Lönnqvist, 2001), and it increases with each subsequent suicide attempt and remains high for more than 20 years (Haw, Bergen, Casey, & Hawton, 2007; Jenkins, Hale, Papanastassiou, Crawford, & Tyrer, 2002). Therefore, special priority must be given to developing effective treatments for this patient group. In the 2014 research agenda of the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention, the "Aspirational Goal Nr. 6: Ensure that people who have attempted suicide can get effective interventions to prevent further attempts" was given the highest priority of all goals (National Action Alliance for Suicide Prevention, 2014, p. 65). This is all the more important as so far there has been scant evidence that specific therapies following attempted suicide actually reduce the risk of a repeat suicide attempt or suicide over a long period. In clinical practice, all too often follow-up treatments – if they are offered to suicidal patients at all – do not even address the issue of suicidality at all.

In the prevention and treatment of suicidality, the main emphasis according to the traditional medical model has been on diagnosis and treatment of mental disorders – first and foremost depression. However, it is debatable how far this approach to the suicidal patient can actually affect suicide rates (De Leo, 2002). It has been argued that the mechanisms of suicidal behavior should be studied independently of any associated psychiatric disorder (Aleman & Denys, 2014; Linehan, 2008).

Various factors that hamper effective treatment of suicidality can be identified. One of these factors is that many patients do not comply with follow-up treatment. After a suicidal crisis, many individuals want to return to their normal daily lives as quickly as possible – that is, they try to forget the suicidal crisis as soon as possible. Up to 50% of attempters refuse outpatient treatment or drop out of follow-up therapy very quickly (Kessler, Berglund, Borges, Nock, & Wang, 2005; Kurz et al., 1988;). In a study, in which we interviewed patients 1 year after attempted suicide, the majority were unable to name a person they could have turned to for help, and a mere 10% said that they might have contacted a health professional. Most people in a suicidal crisis do not seem to think that this is a health problem for which one should see a medical professional. Too often people consider suicidal thoughts as something "private," which they want to keep to themselves, holding onto it as a possible escape in case they should find themselves in a situation with no other way out. Many individuals who have attempted suicide are ashamed and feel no one could understand them or their reasons. Many do not even understand their own suicidal behavior. Individuals at risk of suicide need a special way of communication and