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.

Anja Gysin-Maillart, PhD, is a clinical psychologist and psychotherapist at the outpatients department of the University Hospital of Psychiatry Bern, Switzerland. She is head of the special outpatient clinic for patients who attempted suicide (ASSIP) and is a researcher of the Clinical Research Division at the University Hospital of Bern with a special interest in clinical suicide prevention. Her main focus is on the investigation of therapy processes involved in reducing the risk of repeated suicidal behavior.

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Table of Contents

3 ASSIP Therapist Manual

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]

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[2] special opportunities to talk about their feelings, thoughts, and the background to their suicidal crises. Their motivation to engage in therapy depends to a large extent on the trust in the health professional providing therapy. What they need is nonjudgmental acceptance, empathic understanding, and a therapy model, which helps them to understand the mechanisms of a suicidal crisis, and to develop strategies for dealing with future critical moments in life.

In contrast to those who follow a traditional medical model, in which suicidal impulses are seen as an expression of a mental disorder, the authors of this book understand suicide primarily as a goal-directed action with its own inner logic. An action theoretical model provides a frame that gives room to the very personal experience of a person's suicidal crisis and its background. A key assumption is that people explain their actions with stories, and that the therapist must be open to listening without making rash attributions, because the suicidal person alone is the "expert" of his or her

own story. In an action theoretical context, these stories explain how suicide can become a goal when important life and identity issues are threatened and no alternative coping or action strategies are available. In an acute mental state full of anguish, pain, despair, hopelessness, and helplessness, suicide may appear as the solution that will put an end to the unbearable mental condition.

Follow-up studies strongly suggest that when a person has attempted suicide, the risk of future suicidal behavior, including death by suicide, cannot be "cured." Once a person has tried to solve an emotional crisis with a suicide attempt, this behavioral pattern will quickly reemerge in similar future situations, not only because a suicide attempt provides a solution (albeit temporary), but also because very often it is associated with an immediate sense of relief. The prevailing view emerging from recent developments in suicide research is that, following attempted suicide, it is crucial to establish individual safety strategies with patients, for coping differently in future emotional crises (Stanley & Brown, 2012). For as many patients as possible to benefit, treatments targeting suicidality should be brief, focused, and, of course, effective (Chesin & Stanley, 2013).

Based on such principles, the two authors developed the Attempted Suicide Short Intervention Program (ASSIP), a brief therapy specifically designed for patients after attempted suicide. The key elements of ASSIP are:

- activation of the suicidal crisis by means of a video-recorded narrative interview in a safe environment;
- reactivation of, and distancing from, the suicidal mode through guided video playback of the narrative interview, identification of the suicide-specific emotions and cognitions, and development of new cognitive schemata, complemented by a psychoeducational handout;
- written formulation of long-term goals, individual warning signs, and safety strategies for future suicidal crises;
- video-prompted reexposure to the recent suicidal crisis, aimed at testing and strengthening the safety strategies;

- credit card-sized list of personal early warning signs and individual safety measures;
- continued contact with the patient for 2 years with regular correspondence.

ASSIP combines aspects of action theory, CBT, and attachment theory. A fundamental assumption is that an action theoretical approach to the suicidal patient will establish a therapeutic alliance in the sense of a "secure base" (Bowlby, 1980; Holmes, 2001), which[3] will enhance the effect of the regular correspondence following the four treatment sessions. ASSIP is not a stand-alone therapy but should be offered to suicidal patients in addition to the usual clinical management and follow-up treatment.

[4] [5] # 2 Suicide and Attempted Suicide

2.1 Definitions

Suicide is the act of deliberately killing oneself. This definition includes intentional actions such as overdosing, hanging, shooting, etc,, and omission of life-saving measures – for example, refusing dialysis in renal failure. The concept of suicide as a "willed" action stands in contrast to the close association of suicide with psychiatric disorders (Barraclough, Bunch, Nelson, & Sainsbury, 1974; Isometsä et al., 1995) as well as the reports of suicide attempters who say that during the suicidal crisis they were in an out-of-the-ordinary state of mind, acting like in a trance (Orbach, 1994). The so-called rational suicide, where a suicide is believed to be a rational decision by a mentally healthy person is generally thought to be a rare exception, if it exists at all (Dörner, 1993).

Attempted suicide (Suizidversuch) was defined by Erwin Stengel (1964) as a form of deliberate self-harm limited to a short period of time where the suicidal person cannot know whether or not he or she will survive. Stengel referred to suicide attempts with only limited intention to die, as parasuicide or parasuicidal acts. Wilhelm Feuerlein (1971) sought a further differentiation based on the seriousness and the motives of the self-harm and introduced the terms *parasuicidal pause* (interruption of an unbearable situation) and *parasuicidal gesture*" (with a communicative or appellative aspect). The WHO/EURO multicenter study on suicide and attempted suicide (Platt et al., 1992) defined attempted suicide as

> an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behavior that, without intervention from others, will cause selfharm, or deliberately ingests a substance in