# The Aeschi Working Group: 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.*