



FROM THE PRESIDENT

At the heart and soul of a public health approach to suicide prevention is a mental health approach; this is true at least in the developed countries around the globe. A large number of prevention programmes are based on a case-finding model. Gatekeeper programmes, screening programmes, public education and awareness programmes, for example, are designed to increase early detection of, referral for, and treatment of those at risk. A great deal of work has gone into developing these approaches, but each will fail to accomplish a reduction in suicide mortality and morbidity if they stand alone, unlinked to other links on the chain toward this end. Inherent in the success of these approaches are pathway roadblocks, many of which suicide prevention and mental health communities have yet to adequately address. To wit:

1. If we find and refer someone presumed to be at risk for suicide, will they seek the referred-for treatment?
2. If we find and refer someone presumed to be at risk for suicide, do we have sufficiently competent, trained clinical caregivers to whom they will be referred?
3. If they seek the referred-for treatment, will they adhere to the offered treatment recommendations?
4. If they adhere to treatment recommendations, will the implemented treatments be guideline-concordant and effective in reducing their assessed risk?

I suggest we are not doing all that well at any of these steps. Only a minority of those most at risk follow up on referrals and seek treatment (step 1). There are painfully few clinical providers well-trained in assessing and treating those acutely suicidal (step 2), hence the majority of those who do make consultation appointments do so with ill-prepared caregivers. Rates of adherence among those who do seek treatment are woefully low (step 3). Lastly, where we have guidelines, they are rarely followed, and we have an insufficient array of evidence-based treatments to offer anyway (step 4).

Considerable effort is being expended to better define treatments that work and the literature offers some promising efforts to increase adherence to

our offered treatments. Moreover, in many countries, there is a concerted effort to upgrade the competencies of clinical care providers, although progress here is painfully slow and far too many caregivers simply do not know how to reasonably assess and formulate a patient's risk, beyond merely asking about the presence of suicide ideation. Of great concern is how little attention is being given to improve and increase the rate of help-seeking and, thus, help-receiving by those at risk.

A recently published study is a case in point.

Researchers from the Mayo Clinic, Johns Hopkins and other esteemed institutions reported in the January issue of the *Archives of Surgery*¹ on a cross sectional survey of almost 8,000 US surgeons (87% of whom were males). Their central finding: 6.3% reported suicide ideation in the last 12 months, only 26% of whom had sought mental health care, a rate of help-seeking only slightly more than half that of the general US population (44%). The authors noted that US surgeons are overwhelmingly insured, have ready access to medical (and other) care, and are well aware of the implications of untreated mental health problems. Thus, the low rate of help-seeking is particularly profound, given the absence of these barriers. Further, the primary disincentive to help-seeking reported by these surgeons at risk was their concern that seeking professional help and, correspondingly, having to identify the presence of a mental illness to their medical boards could affect their medical licensing. One terrifying consequence of not seeking help identified in this survey was a finding of an independent association between perceptions of having made a major medical error in the previous 3 months and having had suicide ideation in the past 12 months. Bottom line message: Better to put someone else's life at risk than to seek help to make your own better!

This is just one example of where we need to expend significantly greater effort to remove or lower barriers to care and to shift attitudes and behavior, such that we can better achieve our prevention goals. Keeping in mind that this model of prevention and its attendant problems to be solved is specific to the developed world, I can only imagine the magnitude of problems to be solved in the developing world.

Lanny Berman, Ph.D., ABPP

¹Shanafelt, T D, Balch, C M, Dyrbye, L, Bechamps, G, Russel, T, Satele, D, et al. (2011). Suicide ideation among American surgeons. *Arch. Surg.*, 146(1), 54–62.

REPORT FROM A NATIONAL REPRESENTATIVE

COUNTRY REPORT FROM DENMARK



Officially, the national (governmental) suicide prevention programme ended in 2004. But that did not mean that governmental funding for suicide prevention dried up. During the years thereafter, the funding went towards a variety of projects and initiatives locally, regionally and nationwide.

During the period 2005–2009 the Danish Ministry of Social Affairs (www.vfm.dk) initiated funding for a follow-up of the national prevention programme, mainly focused on suicide attempts among young people, suicidal behaviour in the elderly (primarily men), and suicidal behaviour among psychiatric patients. Furthermore, funding from the Danish Ministry of Interior and Health (www.sum.dk) for the coming years was allocated to establish specialised prevention (and treatment) centres in each of the five Danish Regions. On the one hand these centres focus on quality assured treatment for all suicide attempters (age groups 15+). Yet they aim to reach a greater number of men and the elderly population with suicide attempts (65+). New initiatives will be taken to give better information to these groups. At the same time these centres act as competence and knowledge centres with regard to prevention, treatment and research. One objective is to distribute best practice guidelines to various professionals in areas with a low population density.

Several nationwide research groups were founded in relation to the follow-up of the national suicide prevention programme, and one group is still very active, in particular the research group for suicidal behaviour in the elderly (www.geronet.dk).

One important initiative of this group was the international conference 'The Elderly and Suicide - Research and Prevention' held on the 4th to the 6th of November 2009 in Aalborg. Recommendations from the conference are being disseminated.

Another initiative which started in 2005 during the follow-up period of the national programme, is the regional (the northern part of Zealand) concept called Livsmod, which means 'life courage' (www.livsmod.net). Various professionals (approximately 500) such as psychologists, psychiatrists, teachers, nurses and others from eleven municipalities are part of a competence-lifting network, focusing on the broad range of challenges associated with children and adolescents showing suicidal behaviour and/or eating disorders, cutting etc.

An organisation for surviving relatives and bereaved has been established (www.eterladte.dk) and survivors can get psychological help through visitation from their general practitioner. Also an organisation for relatives of suicide attempters has been established (www.nefos.dk). At the moment, the Danish Parliament (Folketinget) continues to discuss various new proposals targeting prevention of suicidal behaviour, for example a proposal regarding a general right to treatment within 48 hours of a suicide attempt, and a proposal regarding establishing of a national council for the prevention of suicidal behaviour.

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Gert Jessen is IASP National Representative for Denmark

COUNTRY REPORT FROM GERMANY

In Germany, every year about 10,000 people die by suicide. In 2009 the suicide rate per 100,000 was in total 10.4, in men 15.95 and in women 5.69. In Germany, the suicide risk follows the Hungarian pattern and increases with age. Older people are at particular risk for suicide. The suicide rate has been declining over the past decade - with 2009 as an exception, possibly due to the suicide of the famous German goal keeper Robert Enke.



Thomas
Bronisch

Suicide prevention in Germany at present is primarily focusing on four main topics:

1. National Suicide Prevention Programme
2. Competence-Network in Medicine with special emphasis on depression and suicidality
3. Nürnberg Alliance Against Depression
4. The Working Group for Research in Suicidal Behaviour
5. Section Suicide within the German Society for Psychiatry Psychotherapy and Neurology

1. In Germany suicide prevention mainly relies on voluntary work. There are many initiatives and institutions all over the country, which cover a broad spectrum of services. In 2002, the *German National Suicide Prevention Program (NaSPro)*, as an initiative of the *Deutsche Gesellschaft für Suizidprävention (DGS) - German Association for Suicide Prevention*, became a reality due to strong efforts of many colleagues, particularly Armin Schmidtke (Würzburg) as chair of the NaSPro and Georg Fiedler (Hamburg) as secretary of the NaSPro. A first inaugural meeting which took place in Berlin on 26th November 2002 highlighted the wide interest of relevant people, organisations and institutions all over Germany, and beyond (WHO, IASP, IASR etc.). Several working groups were initiated.

2. The general structure of the NaSPro consists of two levels; one might speak of a horizontal and a vertical one. The horizontal level consists of different measures (reduction of methods; media; specific interventions), the vertical level is comprised of different groups. There are eighteen task forces in the National Suicide Prevention Programme: primary suicide prevention, workplace, media and public relations, awareness of psychiatric disorders, children and adolescents, elderly, survivors, specific risk groups, specific psychiatric disorders, substance use disorders, medical care, low-

threshold services, networking, and basic and advanced training, law, gender-related aspects and military. Each task force addresses a number of projects in its field. Up to now, almost all task forces have published informative literature. For example, the task force "elderly" published informative literature and a set of slides and a booklet, which can be downloaded from the website of the Ministry for Family, Seniors, Women and Youth. The German National Suicide Prevention Programme is chaired by Professor Armin Schmidtke. More than 80 organizations, institutions, and associations form this alliance. It is monitored by a scientific committee and collaborates with the World Health Organization and the European Network on Suicide Research and Prevention (International chair: Wolfgang Rutz, German chair: Elmar Etzersdorfer, co-chair: Thomas Bronisch). Furthermore, since 2006 Germany has participated under the auspices of the NaSPro in the World Suicide Prevention Day with different topics each year (Age, Youth, Workplace, Prejudices): www.welttag-suizidpraevention.de.

3. Under the umbrella of the "*German Research Network on Depression and Suicidality*" scientists, medical doctors, psychotherapists and several of the most relevant institutions of the German health care system are aligned to examine the overlapping health problems of "depression" and "suicidality" (chair: Ulrich Hegerl). The project addresses professionals and scientists, affected patients and their relatives and the total population at the same time. Comprehensive PR-activities contribute to an overall sensitisation concerning the topics of depression and suicidality and informs about diagnosis and treatment options. The network is funded by the German Ministry of Education and Research and was established in 1999. Since then more than 20 individual projects have been initiated. Meanwhile more and more results of these projects become available and increasing efforts are undertaken to transfer these results into elements of standard health care.

4. Suicidality often occurs in association with inadequately treated depression (>50%). Therefore suicide preventive actions focus on optimizing treatment for depression in order to reduce suicide rates. Over the last ten years we have witnessed national suicide prevention programmes in Germany. The 4-level-intervention programme *Nuremberg Alliance Against Depression* has been implemented nationwide: *The German Alliance Against Depression* comprises over 60 alliance partners and cooperates with *the National Suicide Prevention Programme* (chair: Ulrich Hegerl). Based on the

positive evaluation results of *the Nuremberg Alliance Against Depression*, the programme was implemented in 17 European countries. The effectiveness is currently being evaluated in the European Commission funded OSPI (Optimized Suicide Prevention Programmes and their Implementation in Europe).

5. During the last 30 years *The Working Group for Research in Suicidal Behaviour (Arbeitsgemeinschaft zur Erforschung suizidalen Verhaltens)* of the *German Society for Suicide prevention* (chair: Barbara Schneider, co-chair: Reinhard Lindner) has carried out biannual scientific meetings in the realm of suicide prevention. This has had considerable impact on research activities in Germany as well as special initiatives for prevention and therapy of suicidal behaviour.

6. Suicide research is traditionally part of the research efforts at the German universities as well as part of the health services in psychiatric-psychotherapeutic clinics. *The German Association for Suicide Prevention* has existed since the seventies and is primarily concerned with suicide prevention. A growing interest in issues concerning suicidality emerged in Germany during the last 20 years, which resulted in a special "*Suicide Section (Referat Suizidologie)*" of the *German Society for Psychiatry Psychotherapy and Neurology - Deutsche Gesellschaft für Psychiatry Psychotherapie und Nervenheilkunde (DGPPN)*. This section "*Suicidology*" of the DGPPN is closely connected to the scientific community of the suicide researchers in Germany (chair: Manfred Wolfersdorf, co-chair: Barbara Schneider).

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Publications:

Etzersdorfer E, Bronisch T (2004). Der wissenschaftliche Beitrag des nationalen Suizidpräventionsprogrammes. *Suizidprophylaxe* 31: 78–81.

Hegerl U, Althaus D, Schmidtke A, Niklewski G (2006). The alliance against depression: 2-year evaluation of a community-based intervention to reduce suicidality. *Psychol Med* 36: 1225–1233.

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Wolfersdorf M, Schneider B (2009). Suizidforschung in Deutschland - aktueller Stand. Vortrag am 12/13. Juni 2010 Charité Berlin.

The people behind the IASP News Bulletin

The IASP News Bulletin is an important tool to inform and update IASP members about a wide range of initiatives and activities including reports from national representatives, updates from IASP Task Forces and Special Interest Groups, activities in connection with World Suicide Prevention Day, IASP awards and announcements of conferences.

Considerable thought and work goes into each issue of the IASP News Bulletin.

THE PEOPLE BEHIND THE SCENES OF THE BULLETIN:

Ella Arensman (Cork, Ireland) co-ordinates each issue of the IASP News Bulletin. She invites IASP members to prepare specific contributions, she edits all articles, and on a regular basis she prepares articles around specific themes.

Tony Davis (Adelaide, Australia) takes care of the final editing and proof reading process.

Ellen Jepson (Stavanger, Norway) is the person who formats the text and she does a magnificent job in converting internationally-sourced assorted items of information into the well-designed IASP News Bulletin.

Kenneth Hemmerick (Montréal, Canada) is involved in final proofing of the text and adds links if necessary. He creates a synopsis of the bulletin for the IASP Website, he lists the bulletin with an image on the IASP Web site, including the IASP Resource Directory, and he promotes the bulletin on the IASP FB Fan Page to our over 7,600 fans and on IASP Twitter to our 330 followers.



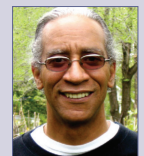
Ella Arensman



Tony Davis



Ellen Jepson



Kenneth
Hemmerick

IASP TASK FORCE ARTICLES:

TASK FORCE on suicide prevention for older people

Studies show that in many countries suicide rates among older adults are higher than, or as high as in young people. However, suicide in old age is a much neglected area. Considering that the number and proportion of the senior population will increase significantly in the coming decades (not only in financially wealthy countries, but also in developing countries), it is probable that the absolute number of suicides in this group will increase accordingly. It was with this problem in mind that a Task Force on Suicide Prevention for Older People was established in 2005 during the IASP Congress in Durban, South Africa.

The objectives of the Task Force are to increase awareness and understanding on suicide in older people, and to assess the efficacy of intervention and prevention programmes, with older adults as the main target group. Two papers have been prepared in collaboration with members of the International Research Group on Suicide among the Elderly, and these will be published shortly in *Crisis*:

1) *A systematic review of suicide prevention programmes for older people*, and 2) *Key considerations for preventing suicide in older adults: Consensus opinions of an expert panel*. Planned activities include a review on psychosocial factors and suicidality in later life (project leader: Margda Waern from Sweden), as well as the organization of symposia at IASP Conferences.

If you would like to become a member of this Task Force, please contact one of the chairpersons:

Annette Erlangsen (e-mail: aerlangsen@jhsph.edu) or Sylvie Lapierre (e-mail: sylvie.lapierre@uqtr.ca)
Professor Sylvie Lapierre, Ph.D, Co-Chair IASP Task Force on Suicide Prevention for Older People, Director of the Research Laboratory in Gerontology, Dept. of Psychology, Université du Québec à Trois-Rivières, Canada.



Sylvie Lapierre

Annette Erlangsen

TASK FORCE on national systems for certifying suicidal deaths

Restructuring the External Causes of Injury Chapter for ICD-11

By now, we may all have become accustomed to the change from 2010 to 2011. However, there is another 'twenty-ten' to 'twenty-eleven' change to which it may be far more difficult for the suicidology community to become accustomed. I am referring to the planned restructuring of Chapter 20 (External Causes of Injury) of ICD-10 for the update to ICD-11. As mentioned by IASP President Lanny Berman in the last News Bulletin, it is proposed to reduce the current priority given to the coding of Intent.

The World Health Organization convened the Injuries and External Causes Topic Advisory Group which established a number of work groups leading to the production of a Background and Issues document and a Recommendations Paper. These highlighted some important issues needing to be addressed, for example, the need for better criteria for coding intentional self-harm and the underestimation of intentional self-harm because 'accidental' is sometimes the default where there are problems determining intent. Unfortunately, the difficulty in establishing intent is one of the reasons behind the recommendation to prioritise the coding of mechanism and object over intent.

Currently, ICD-10 requires coders to first choose which of six intents applied to the event (accidental, intentional self-harm, assault, undetermined, legal intervention or medical complication). Coders must then choose the mechanism involved (e.g. drowning, poisoning, fall, etc.) and then, where applicable, choose the object that was involved (e.g. sharp object, firearm, motor vehicle, etc.).

The proposal for ICD-11 is that the order of coding be Mechanism-Object-Intent. Therefore, coders will choose from a list of dozens of mechanisms then identify the class, category and type of object involved (as up to 1,000 objects may be specified) and then assign intent. Prioritising the detailed coding of object over the coding of intent is almost certainly going to impact negatively on the completeness and quality of intentional self-harm data. We are all aware of the issues related to data quality in suicidology and we need to do what we can to prevent changes to ICD that will further compromise data quality.

The suicidology community are underrepresented on the groups associated with the proposed recommendations and therefore it is important that the IASP membership make its voice heard. Comments and requests for further information can be addressed to the Dr Paul Corcoran, Chair of the Task Force on National Systems for Certifying Suicidal Deaths at http://www.iasp.info/national_systems_for_certifying_suicidal_deaths.php.

Dr Paul Corcoran, Chair of the Task Force on National Systems for Certifying Suicidal Deaths, Deputy Director/Senior Statistician, National Suicide Research Foundation, Cork, Ireland, paul.corcoran@nsrf.ie



Paul Corcoran

IASP Awards

The International Association for Suicide Prevention (IASP) provides awards for those who have contributed in a significant way to the furthering of the aims of the Association. Awards are presented at the IASP biennial conference.

INSTRUCTIONS: Please send your nomination directly to the Chair person of the appropriate Committee. Attach a brief summary of why you feel the nominee is deserving. Nominees do not necessarily have to be IASP members.

DEADLINE: 31 March 2011

The Stengel Research Award has been provided since 1977 and is named in honour of the late Professor Erwin Stengel, one of the founders of the IASP. This award is for outstanding active research with at least 10 years of scientific activity in the field, as evidenced by number and quality of publications in internationally acknowledged journals. THE CRITERIA FOR SELECTION ARE:

- Outstanding and active research with at least 10 years of scientific activity in the field, as evidenced by the number and quality of publications in internationally acknowledged journals.

THE STENGEL RESEARCH AWARD CHAIR PERSON:

Prof. Kees van Heeringen, University of Ghent, Department of Psychiatry, Unit of Suicide Research, De Pintelaan 185, B-9000 Belgium. Tel: +32 [9] 332 43 30 / Fax +32 [9] 332 49 89. Email: cornelius.vanheeringen@UGent.be

The Ringel Service Award was instituted in 1995 and honours the late Professor Erwin Ringel, the founding President of the Association. This award is for distinguished service in the field of suicidology, and nominations can be made by National Representatives of IASP. THE CRITERIA FOR SELECTION ARE:

- Actively involved in the practice of suicide prevention and crisis intervention and its dissemination
- Acknowledged as a national initiator or leader in the field
- Suicide prevention and/or crisis intervention should be the main portion of his/her work.

RINGEL SERVICE AWARD CHAIR PERSON:

Dr Morton Silverman, 4858 South Dorchester Avenue, Chicago IL 60615-2012, USA. Phone: +1 773 550 8179 / Fax: +1 773 624 3995. E-mail: msilverma@edc.org

The Farberow Award was introduced in 1997 in recognition of Professor Norman Farberow, a founding member and driving force behind the IASP. This award is for a person who has contributed significantly in the field of work with survivors of suicide, and nominations can be made by any member of IASP. THE CRITERIA FOR SELECTION ARE:

- Has been actively involved in the establishment and operation of bereaved by suicide/survivor programs
- Has demonstrated national leadership in the area
- Has contributed to the research and evaluation of such program
- Will continue to be involved in this important area of work.

FARBEROW AWARD CHAIR PERSON:

Karl Andriessen, Vaartdijk 60, 2800 Mechelen, Belgium. Phone: +32 [9] 233 50 99 / Fax: +32 [9] 233 35 89. Email: karl.andriessen@pandora.be

The De Leo Fund Award honours the memory of Nicola and Vittorio, the beloved children of Professor Diego De Leo, IASP Past President. The Award is offered to distinguished scholars in recognition of their outstanding research on suicidal behaviours carried out in developing countries. Members of the International Association for Suicide Prevention (IASP) are invited to nominate suitable persons for the De Leo Fund Award. It is for the person who in the view of the award committee has contributed significantly to developing suicide research in a developing country. Nominees do not necessarily have to be IASP members. TO BE ELIGIBLE FOR THE DE LEO FUND AWARD, CANDIDATES SHOULD DEMONSTRATE THE FOLLOWING CRITERIA:

- Be born in a developing country
- Have performed their research in a developing country
- Be a young/mid career researcher (no more than 20 years from graduation), with a prevailing interest in research in the field of suicide
- Be able to demonstrate, through publications in internationally indexed journals, their competence in the field of suicide
- Not to be a current nominee for any other IASP Award.

DE LEO FUND AWARD CHAIR PERSON:

Prof. Diego De Leo, Australian Institute for Suicide Research and Prevention, Griffith University, 176 Messines Ridge Rd, Mt. Gravatt Campus, Mt Gravatt QLD 4122, Australia. Phone: +61 7 3735 3377 / Fax: +61 7 3735 3450. E-mail: D.DeLeo@griffith.edu.au

IASP World Congress in Beijing

IASP's 26th World Congress will be held in Beijing from September 13th to 17th, 2011. This is the second time a world conference on suicide prevention will be held in Asia. The first was in India in 2001— highlighting the important role of the Asia-Pacific in the global effort to reduce the toll of suicide. The relatively high rate of suicide in many countries in the region has stimulated researchers, clinicians and policy makers to develop and assess a range of innovative methods for addressing the problem of suicide. These efforts have drawn attention to the crucial role of culture in the understanding and prevention of suicide, so cultural perspectives has been selected as the central theme for the congress.

The Congress will bring together the dynamic forces of rapidly transforming Asia with the rich experience of experts from other parts of the world, where there is a much longer history of working in the field of suicidology. Asian countries face many of the same challenges in suicide research and suicide prevention experienced by other parts of the world. But the limited health and mental health resources, large rural populations, rapid economic changes and ongoing political reforms in many Asian countries make it difficult to apply the standard methods of addressing these challenges developed in Western countries over the last several decades. Much of what is happening in China and other parts of the Asia-Pacific region is throwing new light on old problems, so the Congress will be a platform for exchanging ideas, renewing old friendships and, most importantly, for initiating new collaborative ventures.



Yueqin Huang

The congress will include an exciting selection of plenary sessions by established and up and coming experts. Symposia, workshops, debates and master's classes will cover the full range of topics of interest to those working towards the global goal of preventing suicide and of improving our methods for dealing with the consequences of suicidal behaviour. A variety of social activities will be arranged for first visitors and old friends who wish to explore the rapidly transforming culture of China's capital or make side visits to other parts of China.

Welcome to Beijing in September 2011!

Yueqin Huang, MD, MPH, PhD
Professor of Psychiatric Epidemiology, Institute of Mental Health, Peking University, Beijing

Important Deadlines

- 1 January, 2011:** Registration opens
- 31 March, 2011:** Deadline for abstract submission
- 1 May, 2011:** Response to authors about acceptance of abstracts
- 15 June, 2011:** Deadline for authors of abstracts accepted as oral presentations to confirm attendance

A limited amount of bursary support for the registration fee is made available by *Peter Lee Care for Life Foundation* to the participants from low income countries who is going to make a presentation (oral/poster) in the congress. Please submit a brief CV to Paul Yip, co-chair of the scientific committee for consideration. E-mail: sfpyip@hkucc.hku.hk

Congress Contact Details

Telephone/Fax number: 010-8280 5411
E-mail: secretary@iaspchina.org academic@iaspchina.org
Website: www.iaspchina.org

Sixth Aeschi Conference



Konrad Michel

In the year 2000 our team from the University Psychiatric Hospital in Bern invited a number of international experts in suicide prevention to discuss the results of a clinical study which analysed narrative interviews with patients who had attempted suicide. This 3-day conference was held in a conference hotel in Aeschi, a village in the Swiss Alps. The meeting had a remarkable dynamic and resulted in the foundation of the "Aeschi Working Group". This group of clinicians and researchers produced a paper with guidelines for clinicians (1), and, above all, decided to open up the circle by inviting interested clinicians and researchers to future "Aeschi Conferences" (<http://www.aeschiconference.unibe.ch>).

These biennial conferences have become an internationally acclaimed institution in the field of clinical suicide prevention. They are exceptional in that for three days they bring together in a very personal and creative setting clinically oriented suicide experts and practitioners. The Aeschi Working Group, together with other clinical experts, have recently published an edited book reflecting the "Aeschi philosophy" (2).

The theme of the sixth conference (20th-23rd March 2011) is *Trauma and Suicide*. Accumulating research – psychological, genetic, and neurobiological – has in recent years emphasized the importance of the trauma concept as a central etiological element for suicide. Research results will be discussed in the context of patients' personal suicidal developments. The presentations and workshops will range from basic considerations of the effects of trauma to more specific discussions of child abuse and war trauma as they bear on suicidality and its therapy.

Professor Konrad Michel, Psychiatric Outpatient Clinic, University Hospital, Bern, Switzerland practice. E-mail: konrad.michel@spk.unibe.ch

References:

- 1) Michel K, Maltzberger 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.
- 2) Michel K & Jobes DA (Eds.). *Building a Therapeutic Alliance with the Suicidal Patient*. APA Books, Washington DC, 2010.

Integrating Cultural Perspectives in the Understanding and Prevention of Suicide



XXVI IASP World Congress
13-17 September, 2011
Beijing, China



Elections IASP Executive Committee

Please note that the elections for the Executive Committee are underway. If you did not receive nomination papers, it may be due to the fact that the Central Administrative Office has yet to receive payment for 2010 or 2011 membership fees. If you have paid your membership fee and not received nomination papers, please contact the Central Administrative Office at admin@iasp.info as soon as possible and these papers will be sent to you immediately.

The Aeschi Working Group

The therapeutic approach to the suicidal patient: New perspectives for health professionals



6th AESCHI CONFERENCE 20th-23rd March 2011

Patient-Oriented Concepts of Suicide: Trauma and Suicide
Hotel Aeschi Park, Aeschi, Switzerland

www.aeschiconference.unibe.ch



44th American Association of Suicidology Annual Conference
Changing the Legacy of Suicide
April 13th - 16th, 2011

Hilton Portland & Executive Towers, Portland, OR, USA
For further information, see www.suicidology.org

American Association of Suicidology (AAS)