THERAPEUTIC ASSESSMENT FOR ADOLESCENT SELF-HARM training workshop

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Declaration of Interest: Royalties from Hodder Arnold (DO and TZ)
AIMS AND OBJECTIVES

• INTRODUCE THERAPEUTIC ASSESSMENT
• CREATE A TA DIAGRAM
• CREATE AN EXIT

Suicides in the UK (ONS 2016)

N=6,120
Suicide in the UK, males (ONS 2016)

Suicide in the UK, females (ONS 2016)
Suicide in the UK, by country (ONS, 2016)

Suicide in England and Wales (ONS 2016)
Suicide worldwide, males and females

Suicides in the UK (ONS, 2019)

N=5,821, 10.1/100,000 – 2017
N=6,507, 11.2/100,000 - 2018

Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency
Figure 9: Hanging, strangulation and suffocation was the most common suicide method (all grouped together) for males and females in 2018. Proportion of suicide by method and sex, UK, registered in 2018.


Suicide by females

Figure 8: There has been a fall in the suicide rates among females aged over 45 years since 1981 and a significant increase among females aged 10 to 24 years since 2012.

Age-specific suicide rates by broad age groups, females, UK, registered between 1981 and 2018.

Suicide by males

Figure 7: Compared with the previous year, there were significant increases in suicide rates among males aged 10 to 24 years and males aged 75 years and over.

Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency

Suicide in Europe

(Eurostat 2016)

Source: Eurostat (online data code: Mth_cd_0100C)
Suicide by the day of the week

![Graph showing suicide rates by day of the week.]

Self Harm

![Image of self-harm marks on skin.]

Prevalence of self harm in school pupils in countries participating in the Child and Adolescent self harm in Europe (CASE) study by gender (Hawton et al 2006)

<table>
<thead>
<tr>
<th>country</th>
<th>self harm meeting previous year (%)</th>
<th>study criteria lifetime (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>females</td>
<td>males</td>
</tr>
<tr>
<td>England</td>
<td>10.8</td>
<td>3.3</td>
</tr>
<tr>
<td>Ireland</td>
<td>9.1</td>
<td>2.7</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>3.7</td>
<td>1.7</td>
</tr>
<tr>
<td>Belgium</td>
<td>10.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Norway</td>
<td>10.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Hungary</td>
<td>5.9</td>
<td>1.7</td>
</tr>
<tr>
<td>Australia</td>
<td>11.8</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Overall effect of psychological treatment on self harm (Ougrin et al, 2015)
One reason why studies show poor effect (Ougrin and Latif 2011)

<table>
<thead>
<tr>
<th>Study or Subgroup</th>
<th>Events</th>
<th>Total</th>
<th>Weight</th>
<th>IV, Random, 95% CI</th>
<th>Risk Ratio</th>
<th>IV, Random, 95% CI</th>
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<tbody>
<tr>
<td>Chanen 2008</td>
<td>9</td>
<td>44</td>
<td>12</td>
<td>42</td>
<td>0.72 [0.34, 1.52]</td>
<td>0.02</td>
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<tr>
<td>Donaldson 2005</td>
<td>6</td>
<td>21</td>
<td>2</td>
<td>18</td>
<td>2.57 [0.59, 11.20]</td>
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<td>Harrington 1998</td>
<td>22</td>
<td>85</td>
<td>48</td>
<td>77</td>
<td>0.42 [0.28, 0.62]</td>
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<td>Hazel 2009</td>
<td>10</td>
<td>35</td>
<td>14</td>
<td>37</td>
<td>0.76 [0.39, 1.47]</td>
<td>10</td>
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<tr>
<td>Spirito 2002</td>
<td>14</td>
<td>36</td>
<td>17</td>
<td>40</td>
<td>0.92 [0.53, 1.58]</td>
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<td>Wood 2001</td>
<td>9</td>
<td>32</td>
<td>12</td>
<td>31</td>
<td>0.73 [0.36, 1.48]</td>
<td>158</td>
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<tr>
<td>Total (95% CI)</td>
<td>253</td>
<td>245</td>
<td>100.0%</td>
<td>0.71 [0.49, 1.05]</td>
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<td></td>
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<tr>
<td>Total events</td>
<td>70</td>
<td>105</td>
<td></td>
<td></td>
<td>0.02</td>
<td>0.1</td>
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Heterogeneity: Tau² = 0.11; Chi² = 10.03, df = 5 (P = 0.07); I² = 50%
Test for overall effect: Z = 1.73 (P = 0.08)

Follow Up After Self Harm

Number of Young People

- Presentations: 108
- Follow up offered: 86
- Follow up attended: 32
- Engaged with Services: 26
TA: PRINCIPLES

- SELF-HARM ASSESSMENT COULD BE THE ONLY CHANCE TO ENGAGE YOUNG PEOPLE
- YOUNG PEOPLE WITH SELF-HARM COULD BENEFIT FROM DIFFERENT PSYCHOLOGICAL INTERVENTIONS
- YOUNG PEOPLE ARE THE BEST JUDGES OF WHAT MIGHT BE HELPFUL

THERAPISTS AND PATIENTS HAVE DIFFERENT HOPES FROM ASSESSMENT

- **Therapists:**
  - Comprehensive history
  - Risk assessment
  - Safe disposal
  - Engagement

- **Young people:**
  - Understanding self/behaviour
  - Feeling better/hope
  - Explore alternatives to SH
  - Feel motivated
TA IS A TOOLBOX

TA AT A GLANCE

• BASIC HISTORY
• DIAGRAM
• “WHERE DO YOU WANT TO START?”
• CREATE AN EXIT
• SET HOMEWORK
• WRITE A LETTER
TA DIAGRAM

INTERPERSONAL PROBLEMS

NEGATIVE THOUGHTS AND FEELINGS

LONG-TERM NEGATIVE CONSEQUENCES

MALADAPTIVE BEHAVIOUR

SHORT-TERM RELIEF

TA DIAGRAM EXAMPLE

MY BOYFRIEND DUMPED ME

I FEEL BAD

I DON'T GO OUT

CUT SKIN

SHORT-TERM RELIEF
TA DIAGRAM

INTERPERSONAL PROBLEMS

NEGATIVE THOUGHTS AND FEELINGS

LONG-TERM NEGATIVE CONSEQUENCES

MALADAPTIVE BEHAVIOUR

SHORT-TERM RELIEF

TA DIAGRAM EXAMPLE

MY BOYFRIEND DUMPED ME

I AM WORTHLESS

DON’T GO OUT

CUT MYSELF

FEEL BETTER
TA DIAGRAM

- Reciprocal Roles
- Core Pain
- Maintaining Procedures

TA DIAGRAM COMPONENTS: RECIPROCAL ROLES

- Interpersonal problems are conceptualised as repetitive polarised maladaptive patterns of relationships called Reciprocal Roles
TA DIAGRAM COMPONENTS: CORE PAIN

- Frequent enactment of Reciprocal Roles leads to the formation of Core Pain: negative thoughts, beliefs, images, emotions and body sensations

![Diagram showing Core Pain components with reciprocal roles: Controlling, Criticising, Rejecting, Abandoning leading to negative thoughts and feelings.]

TA DIAGRAM COMPONENTS: PROCEDURES

- Patients try to counter the core pain with maladaptive behaviour called procedures

![Diagram showing Procedures components with reciprocal roles: Controlling, Criticising, Rejecting, Abandoning leading to negative thoughts and actions.]

34
Self-harm usually occurs when other procedures fail to bring about relief

- Most frequently encountered behaviours designed to counter core pain:
  - Alcohol/drug use
  - Disordered eating
  - Fights
  - Perfectionism
  - Careless risk taking

Self-harm usually occurs when other procedures fail to bring about relief

- Most frequently encountered cognitions designed to counter core pain:
  - Thought/emotion suppression
  - Rumination
  - Perfectionism

Feel better

I not good enough
I feel sad

Others call me a freak

I bottle up my feelings

I eventually explode

I cut myself
Rejecting

Rejected

I am unlikeable
I am not good enough

Abandoning

Abandoned

I stay at home may speak to no-one

I bottle up my feelings

Feel better briefly but weak pathetic

I cut myself

Feel better briefly but weak pathetic

I smoke cannabis

TA diagram

TA Diagram with exits

I am talented creative and caring

I do things I am good at

I tell others how I feel

Can make a list of options to solve problem

I control cutting

I choose the best solution and learn

Cannabis helps short term but makes problems worse

Music, family, drawing help me control cutting

I control cutting

I choose the best solution and learn

Cannabis helps short term but makes problems worse

I do things I am good at

I tell others how I feel

Can make a list of options to solve problem

I control cutting

I choose the best solution and learn

Cannabis helps short term but makes problems worse

Understanding

Understood

Accepting

Accepted
Understanding Letter

- Describes the diagram
- Highlights the positives/protective factors
- Invites the young person for further work
- Reiterates the time and place of the next appointment

EXERCISE

- READ NADIA’S HISTORY
- RECIPROCAL ROLES?
- CORE PAIN?
- MAINTAINING CYCLE?
TOTAL

- Trial of Therapeutic Assessment in London
- 2 centres: SLAM and Tavistock
- 26 clinicians randomised
- 70 adolescents with SH recruited over 18 months
- Followed up 3 months after SH assessment

TOTAL: PRIMARY OUTCOMES

Attending at least one session: 83% v 49%, p<0.003
TOTAL: PAIRED SAMPLES ANALYSIS

Clinical change

- Mean score
- CGAS
- SDQ
- Assessment
- Follow up

P < 0.05

TOTAL: OTHER OUTCOMES 3 MONTHS POST ASSESSMENT

Treatment offered

- TA
- AAU

- Case management
- Structured Psychotherapy

P < 0.05
TA IN NON-SUICIDAL SELF-HARM

Tests of Between-Subjects Effects

<table>
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<tr>
<th>Source</th>
<th>Type II Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
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<td>Corrected Model</td>
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<td>98.193</td>
<td>11629</td>
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<tr>
<td>Intercept</td>
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<td>Error</td>
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<td>64</td>
<td>98.193</td>
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<tr>
<td>Total</td>
<td>11629.000</td>
<td>65</td>
<td></td>
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<td>Corrected Total</td>
<td>6787.138</td>
<td>64</td>
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</table>

R Squared = .132 (Adjusted R Squared = .074)

CGAS change at 3 months’ follow up

P=0.03

2 YEAR FOLLOW UP: A&E PRESENTATIONS WITH SELF-HARM

p>0.05
A&E PRESENTATIONS WITH SELF HARM

• No significant difference in self-harm between TA and AAU (OR: 0.70 (95% C.I.: 0.23-2.13), z=-0.64, p=0.53)

• Predicted marginal probabilities to present to A&E with self-harm were 0.2 (95% C.I.: 0.07-0.33) in the TA and 0.27 (95% C.I.: 0.12-.41) in the AAU group

• There was no effect of the clinician on A&E self-harm (ICC=0; 95% bootstrap C.I. 0-0.003).

TOTAL NUMBER OF REPORTED SELF HARM EPISODES

• YEAR 1: 20 (29%) YP reported between 1 and 129 episodes of self harm (median=9.5; lower and upper quartiles: 1-33.5)

• YEAR 2: 14 (20%) children reported between 1 and 144 episodes of self harm (median=4.5 lower and upper quartiles: 1-12)

• A random effects Poisson regression did not revealed significant differences between the years IRR=0.56 (95% C.I. = 0.19-1.66), z=-1.04, p=0.30)
TREATMENT ENGAGEMENT

<table>
<thead>
<tr>
<th>group</th>
<th>time</th>
<th>Mean</th>
<th>Std. Err</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>Intervention</td>
<td>4.571</td>
<td>1.146</td>
<td>4.455</td>
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<td></td>
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<td>Control</td>
<td>4.314</td>
<td>1.275</td>
<td>1.789</td>
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**Estimated Marginal Means of MEASURE_1**

CGAS MAXIMUM VALUES

- TA 66.97 (SD=10.87)
- AAU 62.09 (SD=9.31)
- Difference 4.88 95% CI 0.01 to 9.75, p<0.05
CGAS MINIMUM VALUES

• TA 60.00 (SD=13.23)
• AAU 57.79 (SD=11.41)
• Difference 2.21, 95% CI -3.74 to 8.15
  p>0.05

OTHER OUTCOMES

• Non-suicidal self-harm predicted suicide attempts

• No completed suicides

• A range of other outcomes (not pre-specified) favoured TA group
CONCLUSIONS

• TA versus usual assessment increases engagement with follow up

• TA versus usual assessment does not decrease A&E presentations with self harm over 2 years

• TA versus usual assessment is linked with achieving higher maximum functional status over 2 years

CONCLUSIONS

• TA versus usual assessment increases engagement with follow up

• Young people with non-suicidal self-harm have better functional outcomes with TA
CONTACT US

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