THERAPEUTIC ASSESSMENT FOR ADOLESCENT SELF-HARM training workshop

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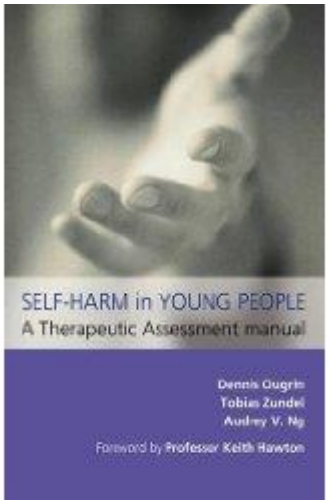
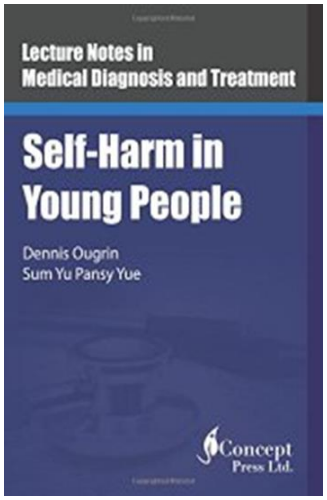
Declaration of Interest: Royalties from Hodder Arnold (DO and TZ)

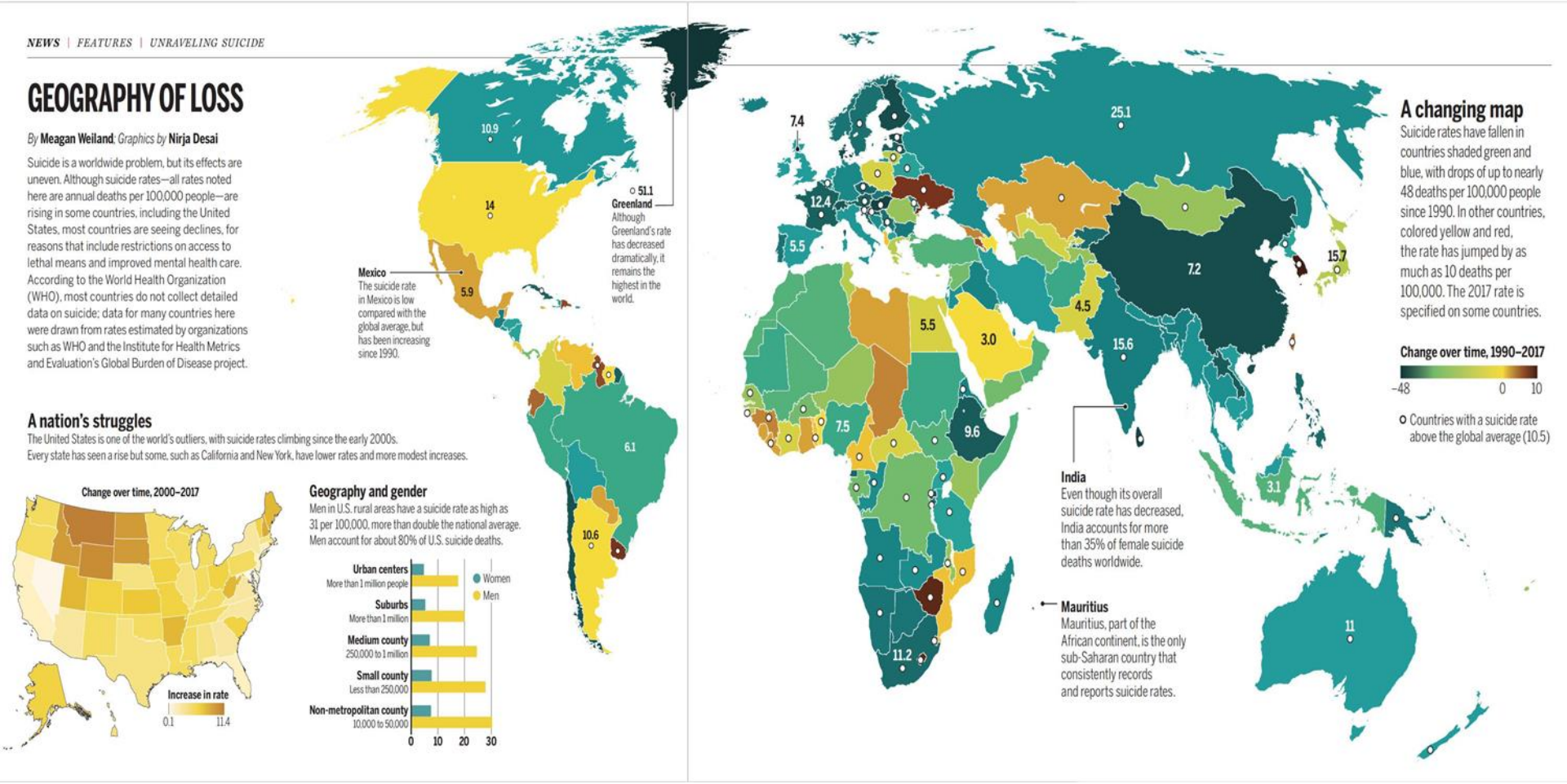




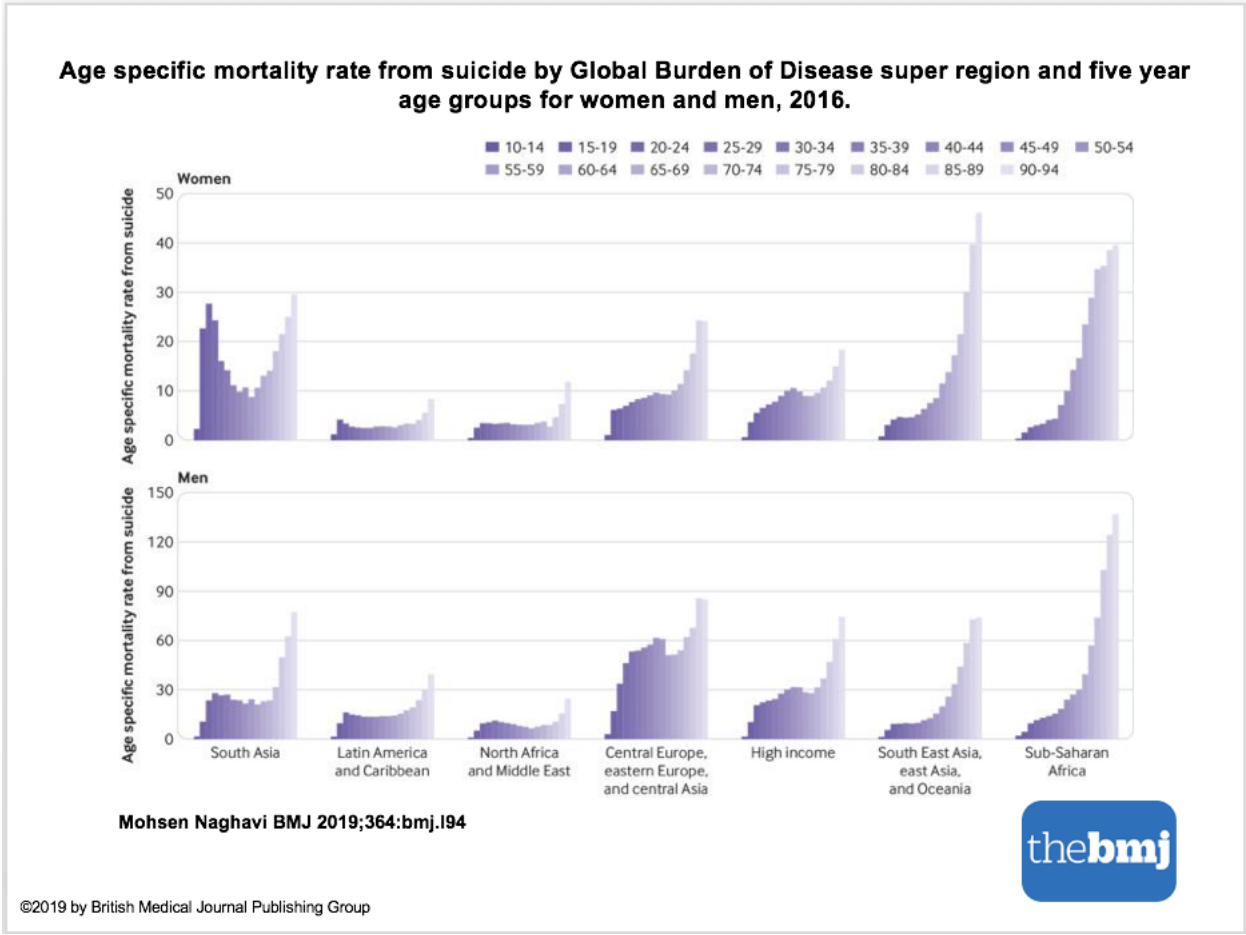
AIMS AND OBJECTIVES

- INTRODUCE THERAPEUTIC ASSESSMENT
- CREATE A TA DIAGRAM
- CREATE AN EXIT
- APPLY TA TO ASD

Suicide worldwide Desai et al, Science, 2019



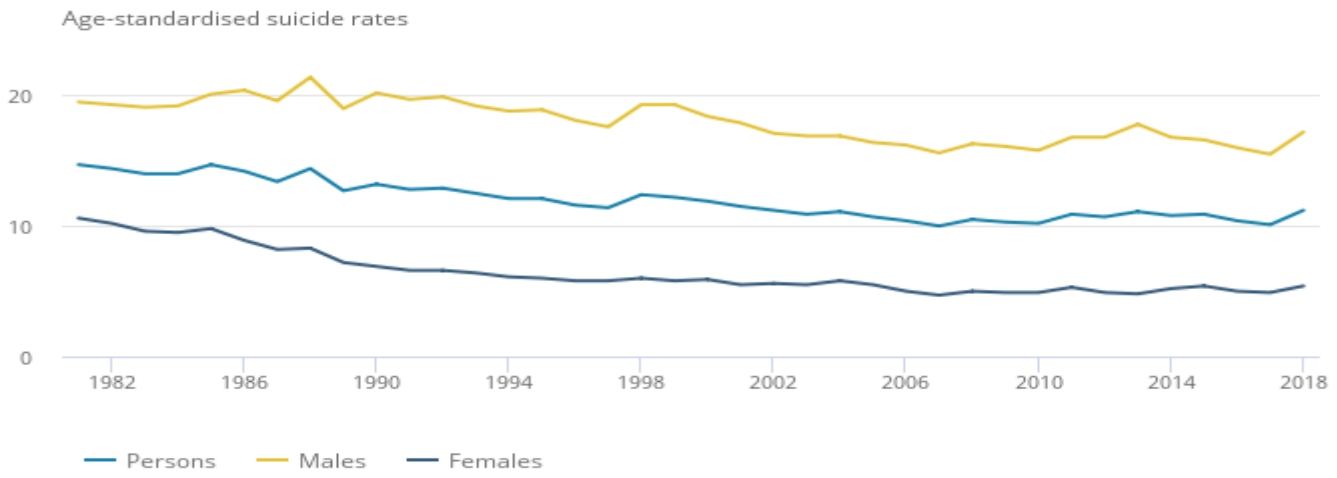
Suicide worldwide, males and females



Suicides in the UK (ONS, 2019)

Figure 1: Significant increase in suicide rates for all persons and males in 2018

Age-standardised suicide rates by sex, UK, registered between 1981 and 2018



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

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

Suicides of 10-18 yr. in England and Wales (ONS, 2020)

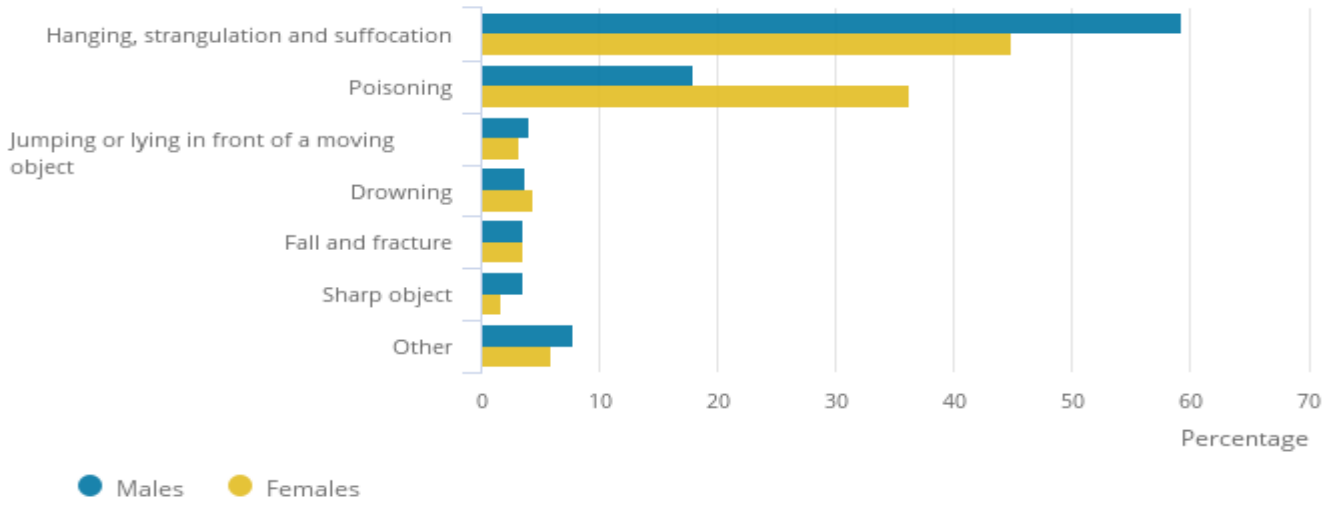
Region code	Name	2014	2015	2016	2017	2018
E12000001	North East	6	7	7	6	4
E12000002	North West	15	23	20	16	21
E12000003	Yorkshire and the Humber	11	16	6	8	11
E12000004	East Midlands	14	12	7	8	8
E12000005	West Midlands	7	3	10	9	11
E12000006	East	13	9	11	13	23
E12000007	London	8	15	13	13	16
E12000008	South East	10	24	22	22	22
E12000009	South West	15	19	10	11	14
W92000004	Wales	9	6	10	11	7

Age	Deaths
10	0
11	2
12	0
13	3
14	6
15	19
16	30
17	28
18	51

Method (ONS, 2019)

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

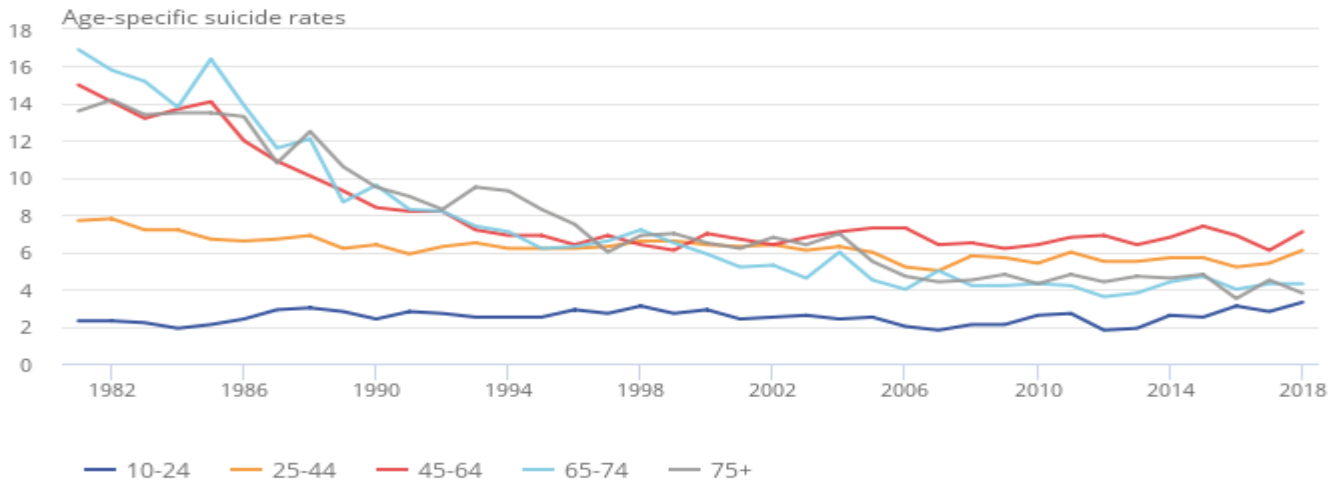


Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency

Suicide by females (ONS, 2019)

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

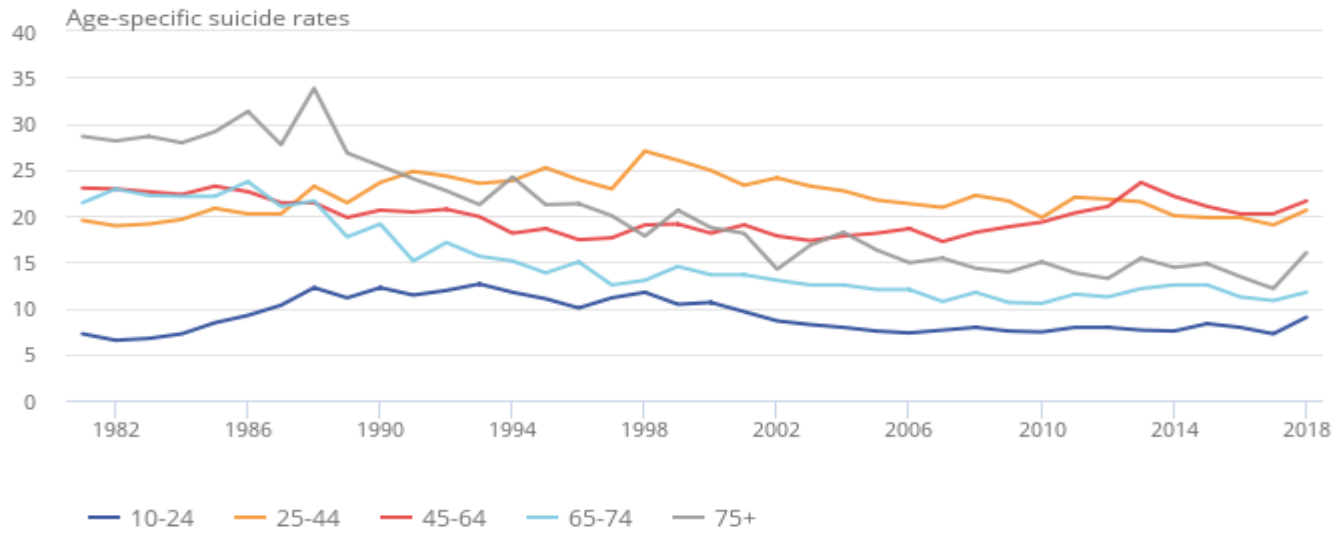


Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency

Suicide by males (ONS, 2019)

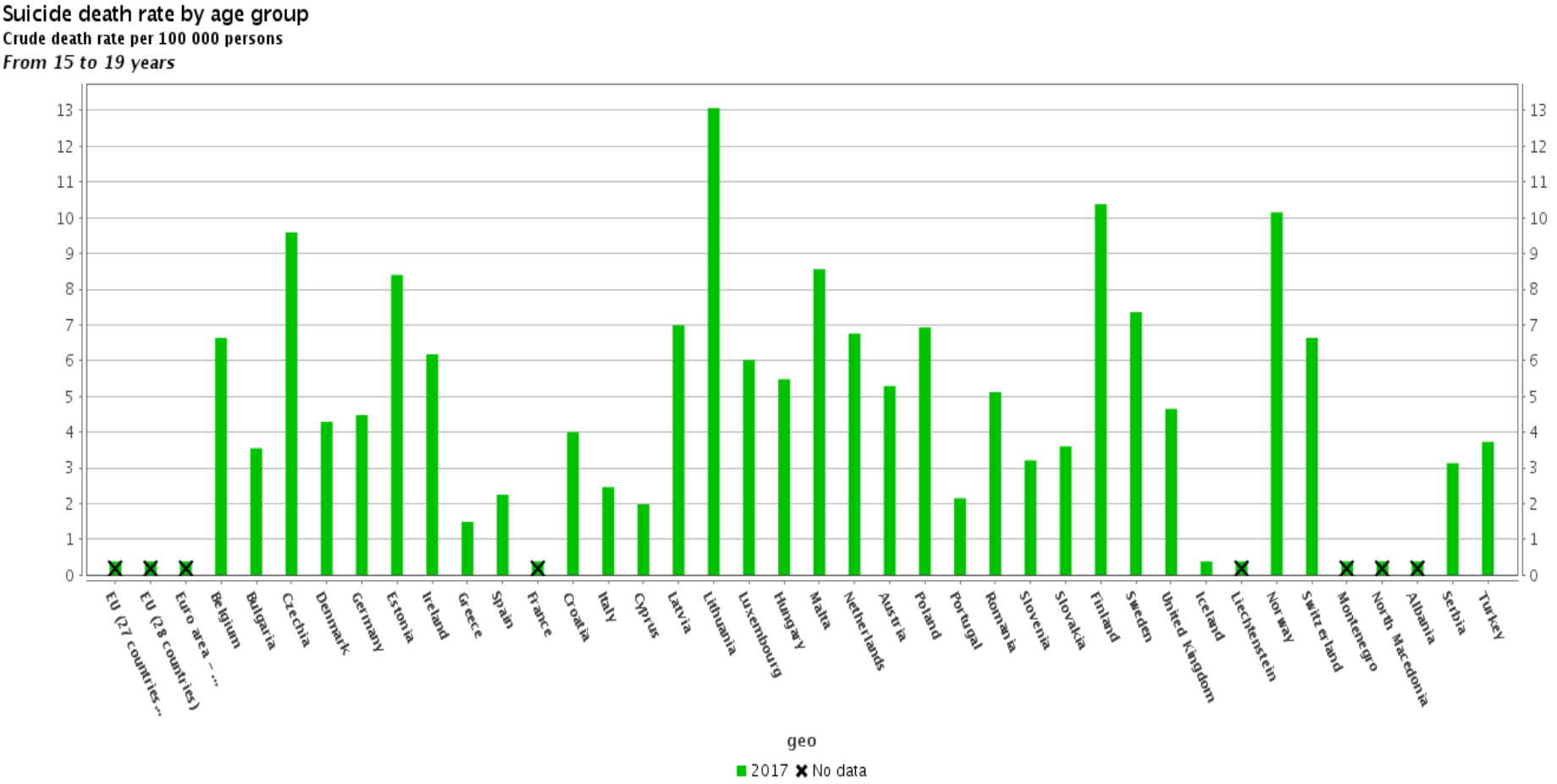
Figure 7: Compared with the previous year, there were significant increases in suicide rates among males aged 10 to 24 years and males aged 75 years and over

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



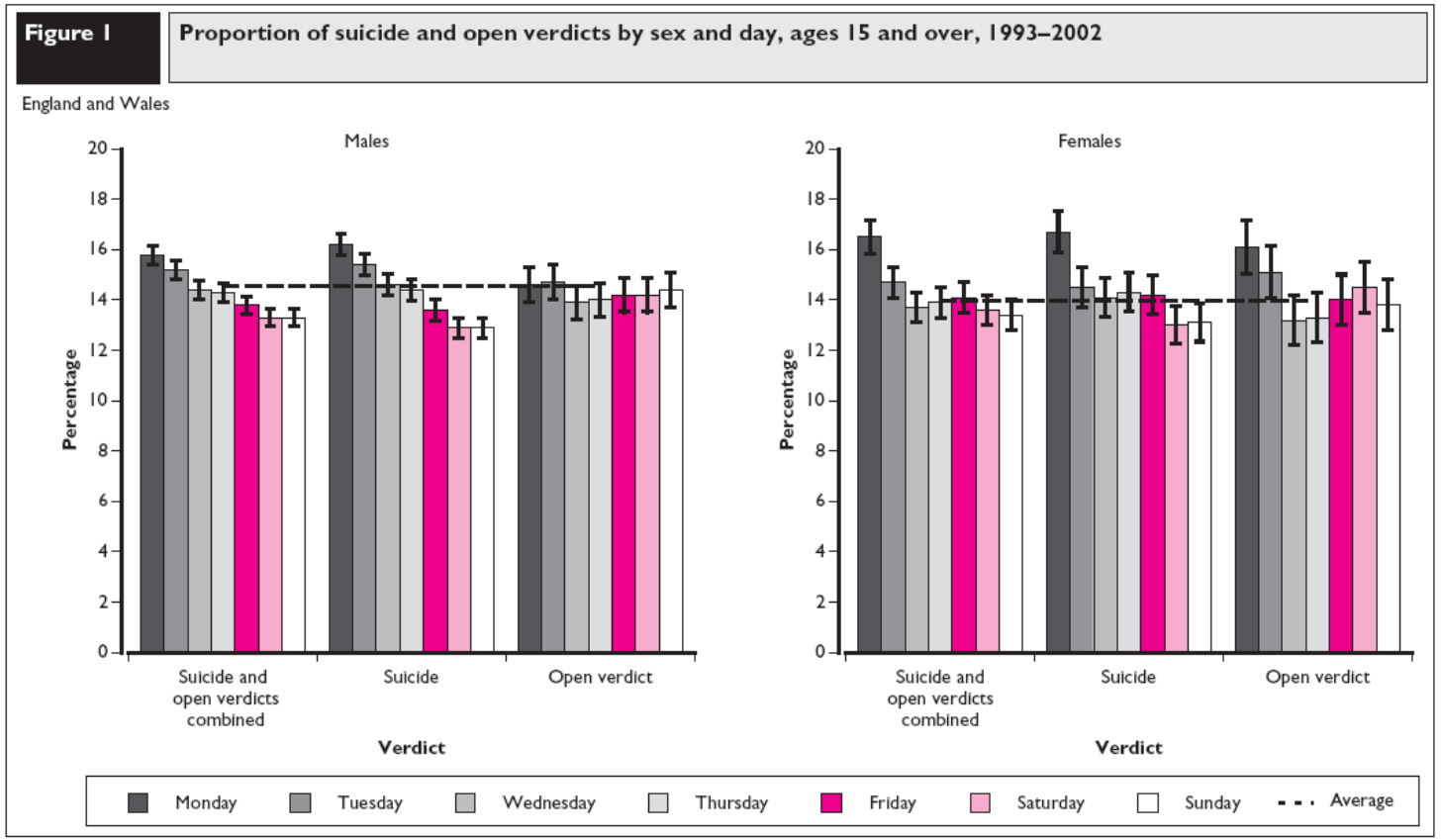
Source: Office for National Statistics, National Records of Scotland, and Northern Ireland Statistics and Research Agency

Suicide in Europe, 2017 (Eurostat 2020)



Source of Data Eurostat
Last update: 02.06.2020
Date of extraction: 01 Jul 2020 13:29:44 CEST
Hyperlink to the graph: https://ec.europa.eu/eurostat/eurostat/tgm/drawGraph.do&init=1&plugin=1&language=en&pcode=tps00202&toolbox=legend

Suicide by the day of the week



Suicide in people with ASD (Hirvikoski et al, 2016)

OR 7.55 (6.04–9.44)

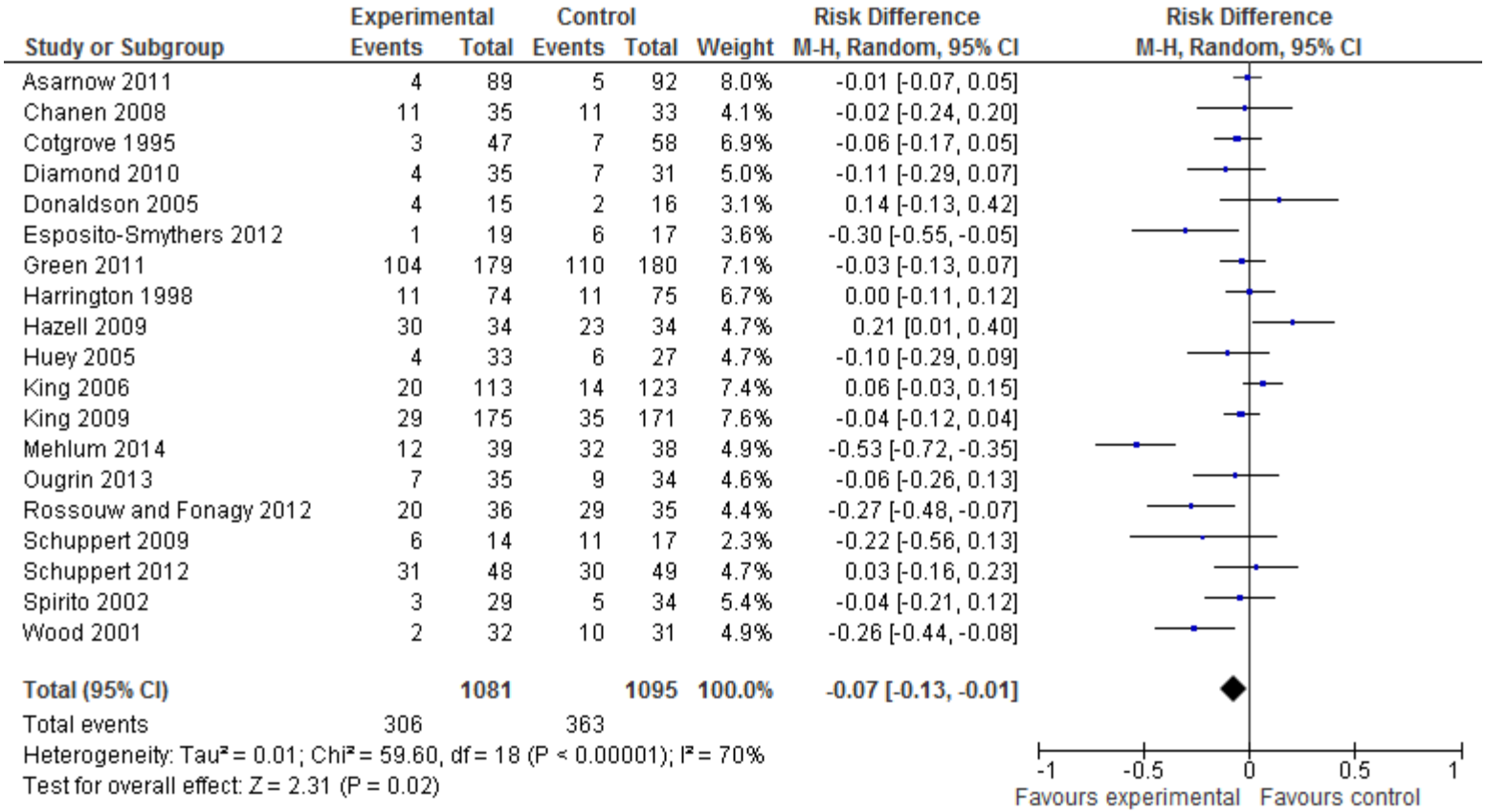
OR 2.41 (1.14–5.11) – with ID

OR 9.40 (7.43–11.90) – without ID

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)

country	self harm meeting		study criteria	
	previous year (%)		lifetime (%)	
	females	males	females	males
England	10.8	3.3	16.9	4.9
Ireland	9.1	2.7	13.5	4.9
The Netherlands	3.7	1.7	5.9	2.5
Belgium	10.4	4.4	15.6	6.8
Norway	10.8	2.5	15.3	4.3
Hungary	5.9	1.7	10.1	3.2
Australia	11.8	1.8	17.1	3.3

Overall effect of psychological treatment on self harm (Ougrin et al, 2015)



Study or Subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Risk Difference M-H, Random, 95% CI
Asarnow 2011	4	89	5	92	8.0%	-0.01 [-0.07, 0.05]
Chanen 2008	11	35	11	33	4.1%	-0.02 [-0.24, 0.20]
Cotgrove 1995	3	47	7	58	6.9%	-0.06 [-0.17, 0.05]
Diamond 2010	4	35	7	31	5.0%	-0.11 [-0.29, 0.07]
Donaldson 2005	4	15	2	16	3.1%	0.14 [-0.13, 0.42]
Esposito-Smythers 2012	1	19	6	17	3.6%	-0.30 [-0.55, -0.05]
Green 2011	104	179	110	180	7.1%	-0.03 [-0.13, 0.07]
Harrington 1998	11	74	11	75	6.7%	0.00 [-0.11, 0.12]
Hazell 2009	30	34	23	34	4.7%	0.21 [0.01, 0.40]
Huey 2005	4	33	6	27	4.7%	-0.10 [-0.29, 0.09]
King 2006	20	113	14	123	7.4%	0.06 [-0.03, 0.15]
King 2009	29	175	35	171	7.6%	-0.04 [-0.12, 0.04]
Mehlum 2014	12	39	32	38	4.9%	-0.53 [-0.72, -0.35]
Ougrin 2013	7	35	9	34	4.6%	-0.06 [-0.26, 0.13]
Rossouw and Fonagy 2012	20	36	29	35	4.4%	-0.27 [-0.48, -0.07]
Schuppert 2009	6	14	11	17	2.3%	-0.22 [-0.56, 0.13]
Schuppert 2012	31	48	30	49	4.7%	0.03 [-0.16, 0.23]
Spirito 2002	3	29	5	34	5.4%	-0.04 [-0.21, 0.12]
Wood 2001	2	32	10	31	4.9%	-0.26 [-0.44, -0.08]
Total (95% CI)		**1081**		**1095**	**100.0%**	**-0.07 [-0.13, -0.01]**
Total events	306		363			

Heterogeneity: $Tau^2 = 0.01$; $Chi^2 = 59.60$, $df = 18$ ($P < 0.00001$); $I^2 = 70\%$

Test for overall effect: $Z = 2.31$ ($P = 0.02$)

Self-harm in young people with ASD (Duerden et al, 2012)

Lifetime prevalence 50%

Key predictors:

- Abnormal sensory processing
- Sameness
- Impaired cognitive ability
- Social functioning

Risk factors for self-harm

- History of NSSI (OR 9.6, 95% CI 3.5–26.1) *Brent et al*
- Suicidal ideation (OR 2.0, 95% CI 1.1–3.8) and depressive symptomatology (OR 2.0, 95% CI 1.0–3.9) *Vitielo et al*
- Rehospitalisation (hazard ratio = 3.13) *Czyz et al*
- Psychotic symptoms (OR 17.91; 95% CI 3.61–88.82) by 3 months (OR 32.67; 95% CI 10.42–102.41) by 12 months *Kelleher et al*
- "hard" versus "soft" method (OR 1.51, 95% CI 1.11–2.05). Previous SA (OR 3.21, 95% CI 2.35–4.40) *Hulten et al*
- Early-onset (< 16 yr.) cannabis use RR = 1.9 *Wilcox et al*
- Among males conduct (OR 5.4; 95% CI 2.4–11.8), hyperkinetic (OR 4.3; 95% CI 1.9–10.0; $p < 0.001$), and emotional (OR 4.3; 95% CI 1.9–9.4) problems *Sourander et al*
- Childhood abuse (OR 2.43- 4.95)
- Bullying victimisation RR 1.92 - 2.44 (OR 5.2 in girls) *Fisher et al.*
- Worries about sexuality (OR 4.82, 95% CI 1.25–18.52) history of sexual abuse (OR 5.26, 95% CI 1.01–27.48), family SH (OR 4.75, 95% CI 1.46–15.47), anxiety (OR 1.30, 95% CI 1.06–1.59) *O'Connor et al*
- Among males: living in a non-intact family (OR 3.8; 95% CI 1.7–8.2) *Sourander et al*
- Family conflict (OR 1.1, 95% CI 1.03–1.16) *Brent et al*
- Low self-esteem (OR 1.99 - 2.58) External attributional style (OR 2.06 - 3.34) *Martin et al*

Protective

- Family cohesion protects from SA (OR 0.90; 95% CI 0.86–0.95) *McKeown et al*
- Good self-esteem (OR 0.82, 95% CI 0.69–0.98) *O'Connor et al*

Transition from suicidal thinking to suicide attempts (Mars et al, 2019)

- presence of psychiatric disorders
- female gender
- lower IQ
- higher impulsivity
- higher intensity seeking
- lower conscientiousness
- a greater number of life events
- body dissatisfaction
- hopelessness

- exposure to self-harm in both friends and family OR 5.26, 95% CI: 3.17-8.74
- smoking OR 2.54, 95% CI 1.61- 4.02
- non-cannabis drug use OR 1.8 95% CI 1.18-2.75

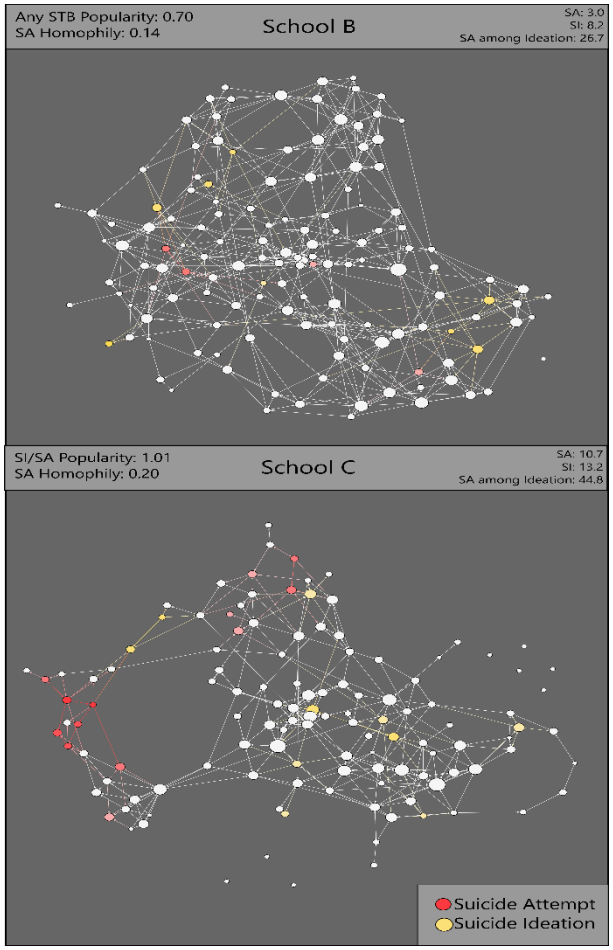
Risk factors for completed suicide

(Hawton et al, 2012)

- Male sex
- Low socioeconomic status
- Restricted educational achievement
- Parental separation or divorce
- Parental death
- Adverse childhood experiences
- Parental mental disorder
- Family history of suicidal behaviour
- Interpersonal difficulties
- Mental disorder
- Drug and alcohol misuse
- Hopelessness

Peer-adult network structure and suicide attempts in 38 high schools: implications for network-informed suicide prevention

Wyman, P.A., Pickering, T.A., Pisani, A.R., Rulison, K., Schmmeelk-Cone, K., Hartley, C., … & Valente, T., JCPP, 2019



- School networks could provide the relationship network structure that will potentially prevent suicidal behaviour
- FINDINGS: Lower peer network integration and cohesion in schools had higher rates of suicidal ideation (SI) and suicide attempts (SA)
- Suicidal attempts increased with two factors:

1. Student isolation

- 10% more students isolated from adults led to 20% higher SA rate on average

2. Popularity of student and clustering on network

-Higher relative to non suicidal peers

Figure shows differing social influence of suicidal youth in two schools. Darkness of shading reflects clustering of students with suicidal thoughts/behaviours (STB). Nodes are sized by in-degree (i.e., popularity). In School B, students with STB are relatively less popular vs. no STB compared to School C. Additionally, students with SA cluster less in School B vs. C. School B has lower SA rates than School C.

Risk assessment: future

- Implicit associations https://implicit.harvard.edu/implicit/user/pimh/index.jsp
- Machine learning

Long term follow up A&E presentations

(Hawton et al, 2012)

- **Repetition in 27.3%**
- age
- self-cutting
- previous self-harm
- psychiatric treatment

- **Death in 1% (50% suicides)**
- The method used was usually different to that used for self-harm.
- male gender
- self-cutting
- prior psychiatric treatment
- history of previous self harm.

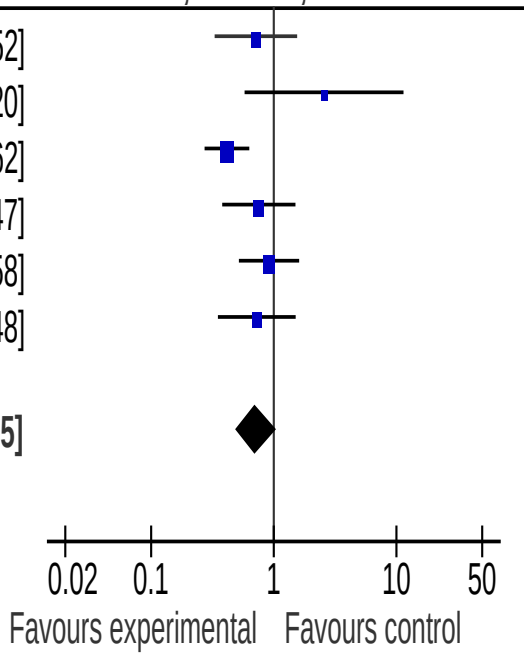
- Violent versus non-violent self-harm makes you 8 times more likely to die (Beckman et al, 2019)

Treatment Engagement Was Poor (Ougrin and Latif 2011)

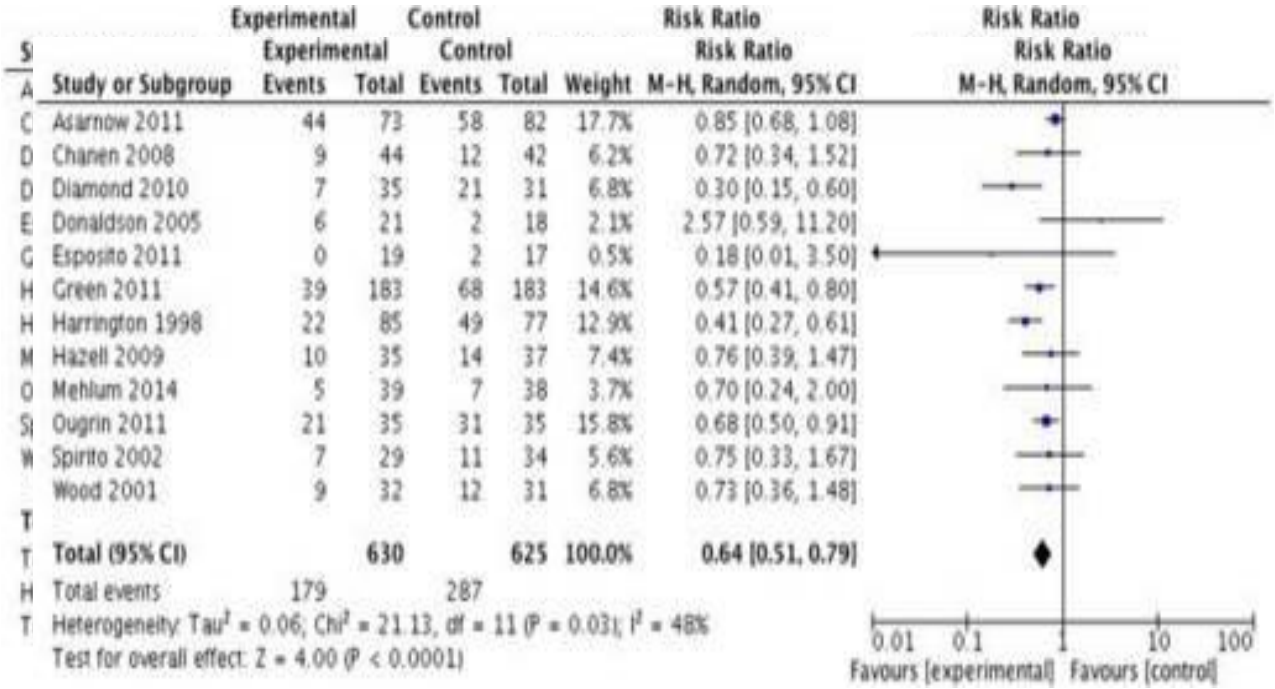
Study or Subgroup	Psychotherapy Events	Total	TAU Events	Total	Weight	Risk Ratio IV, Random, 95% CI
Chanen 2008	9	44	12	42	14.9%	0.72 [0.34, 1.52]
Donaldson 2005	6	21	2	18	5.7%	2.57 [0.59, 11.20]
Harrington 1998	22	85	48	77	25.6%	0.42 [0.28, 0.62]
Hazel 2009	10	35	14	37	17.1%	0.76 [0.39, 1.47]
Spirito 2002	14	36	17	40	20.6%	0.92 [0.53, 1.58]
Wood 2001	9	32	12	31	16.0%	0.73 [0.36, 1.48]
Total (95% CI)		**253**		**245**	**100.0%**	**0.71 [0.49, 1.05]**
Total events	70		105			

Heterogeneity: $Tau^2 = 0.11$; $Chi^2 = 10.03$, df = 5 (P = 0.07); $I^2 = 50\%$

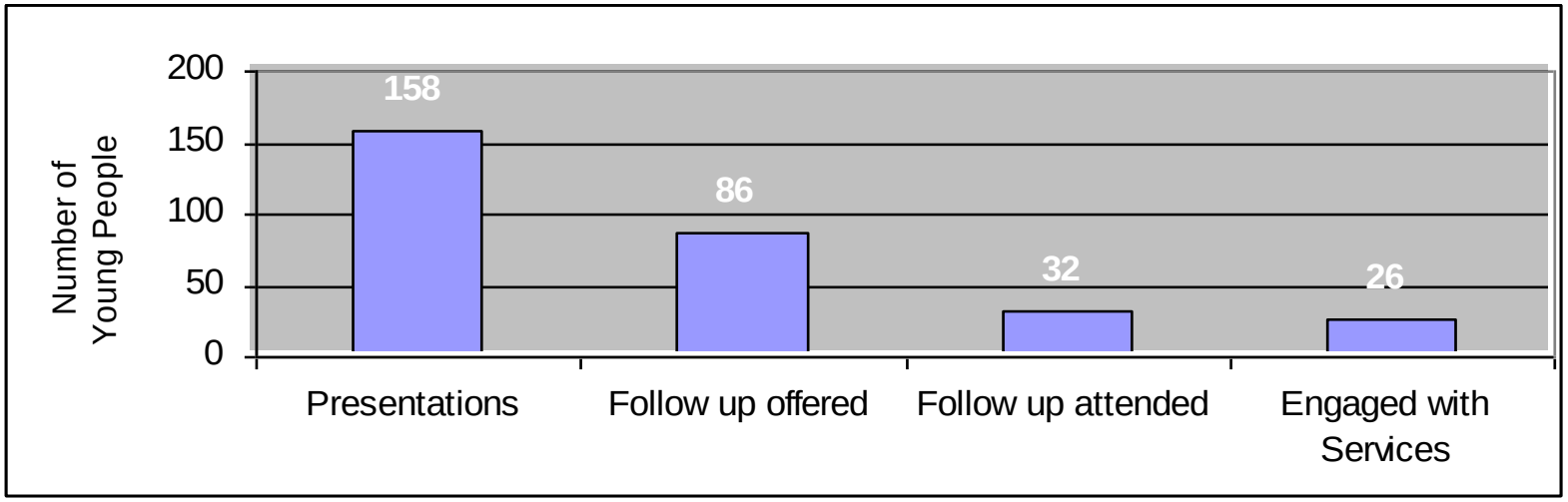
Test for overall effect: Z = 1.73 (P = 0.08)



But getting better (Yuan, Kwok and Ougrin, 2019)



Follow Up After Self Harm



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

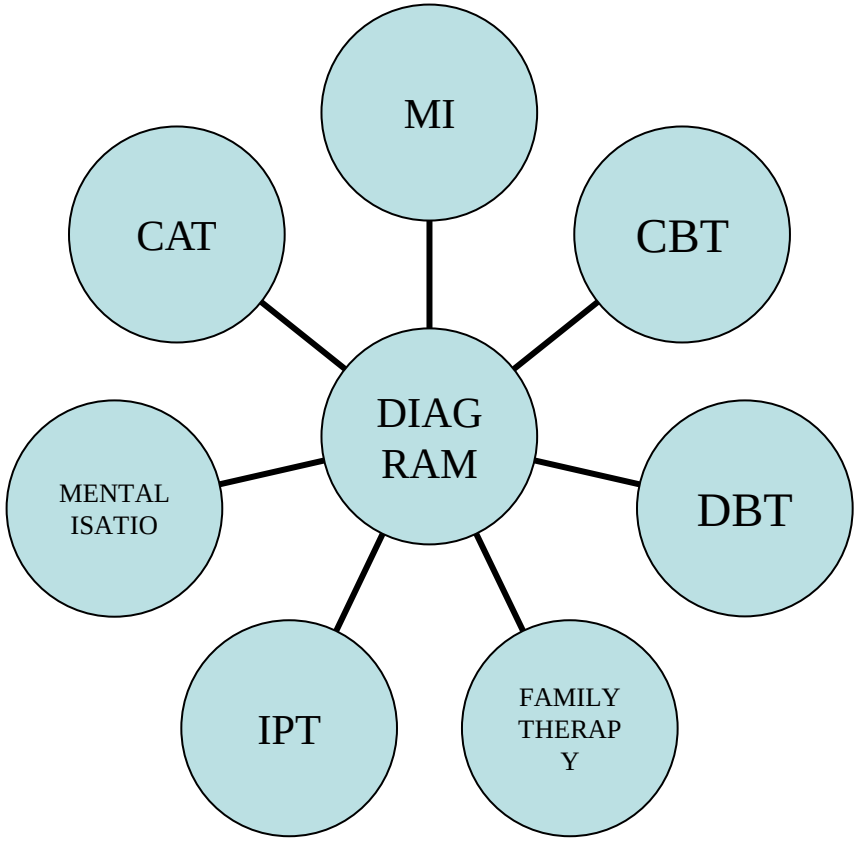
- Therapists:
- Comprehensive history
- Risk assessment
- Safe disposal
- Engagement

- Young people:
- Understanding self/behaviour
- Feeling better/hope
- Explore alternatives to SH
- Feel motivated

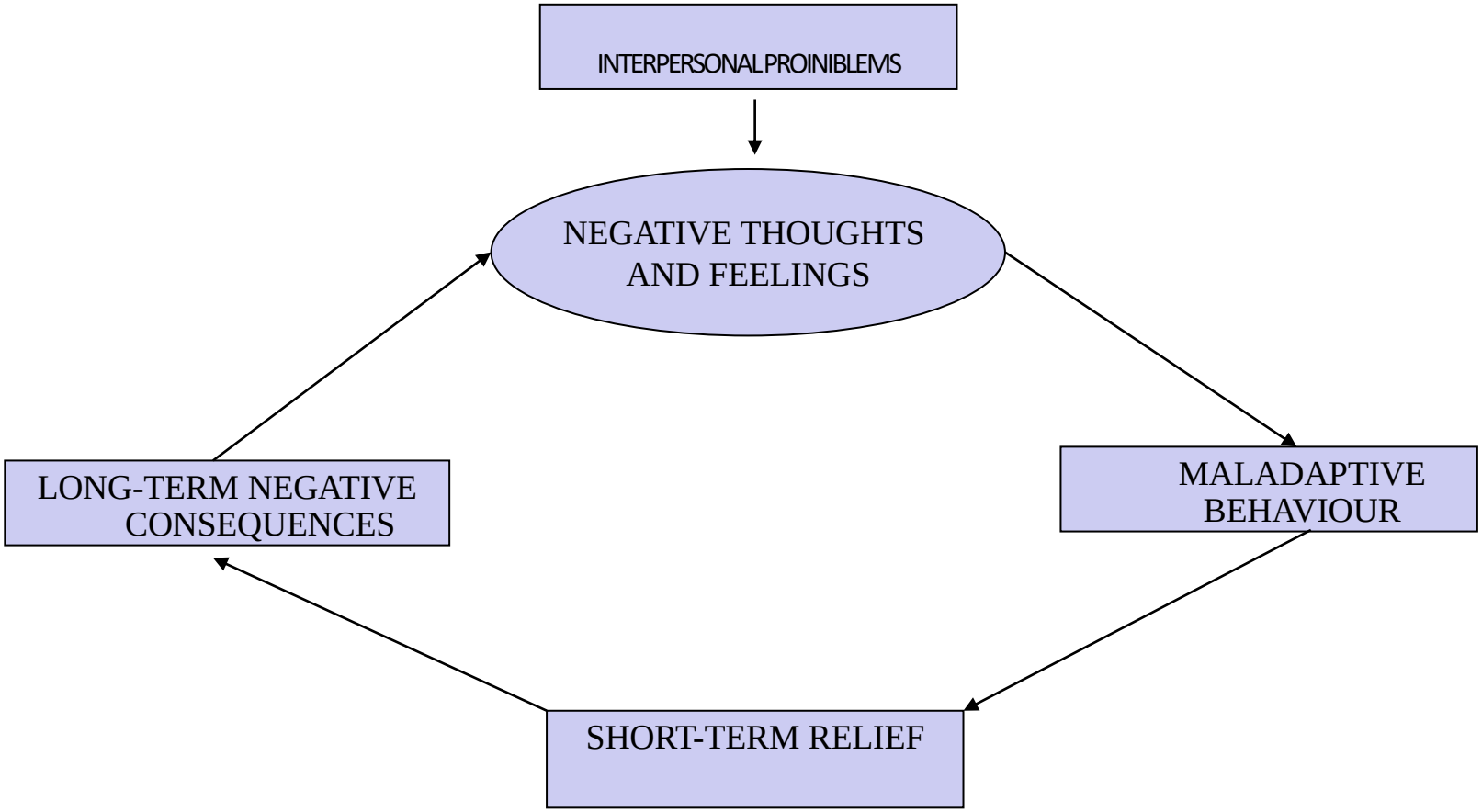
TA IS A TOOLBOX

TA AT A GLANCE

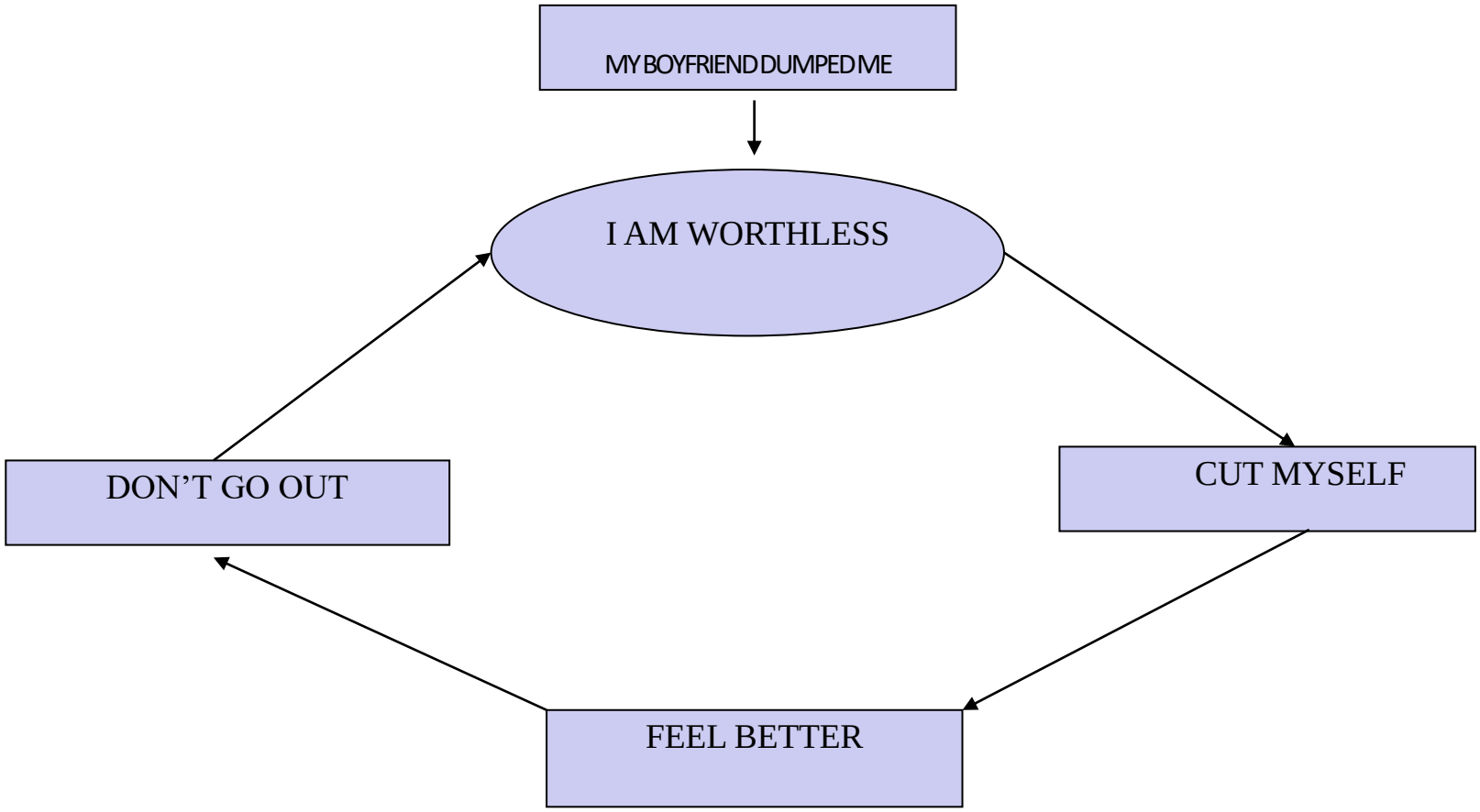
- BASIC HISTORY
- DIAGRAM
- “WHERE DO YOU WANT TO START?”
- CREATE AN EXIT
- SET HOMEWORK
- WRITE A LETTER



TA DIAGRAM


INTERPERSONAL PROINIBLEMS
NEGATIVE THOUGHTS AND FEELINGS
MALADAPTIVE BEHAVIOUR
SHORT-TERM RELIEF
LONG-TERM NEGATIVE CONSEQUENCES

TA DIAGRAM EXAMPLE

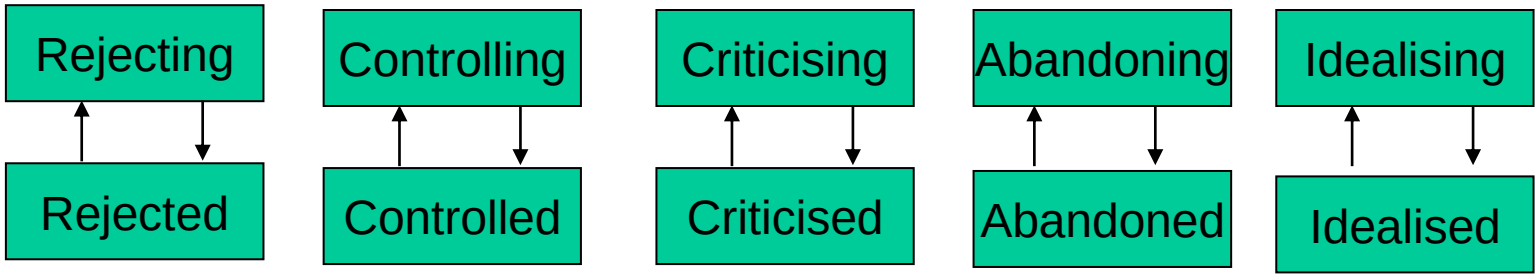


TA DIAGRAM

- Reciprocal Roles
- Core Pain
- Maintaining Procedures

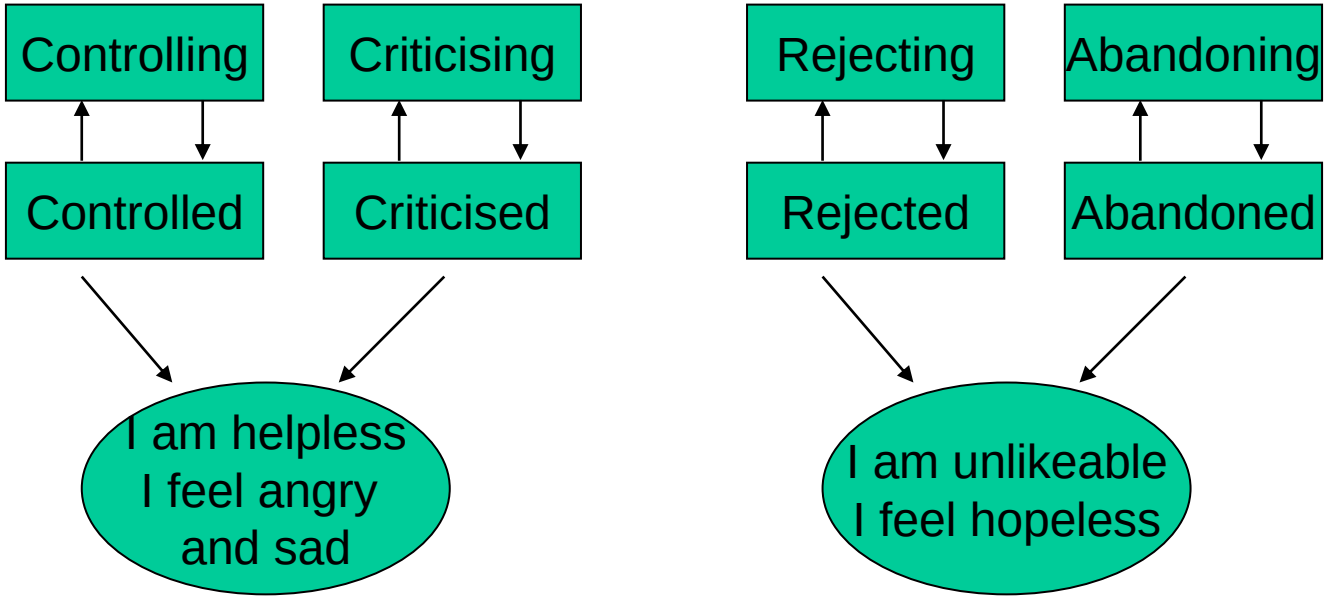
TA DIAGRAM COMPONENTS: RECIPROCAL ROLES

- interpersonal problems are conceptualised as repetitive polarised maladaptive patterns of relationships called Reciprocal Roles



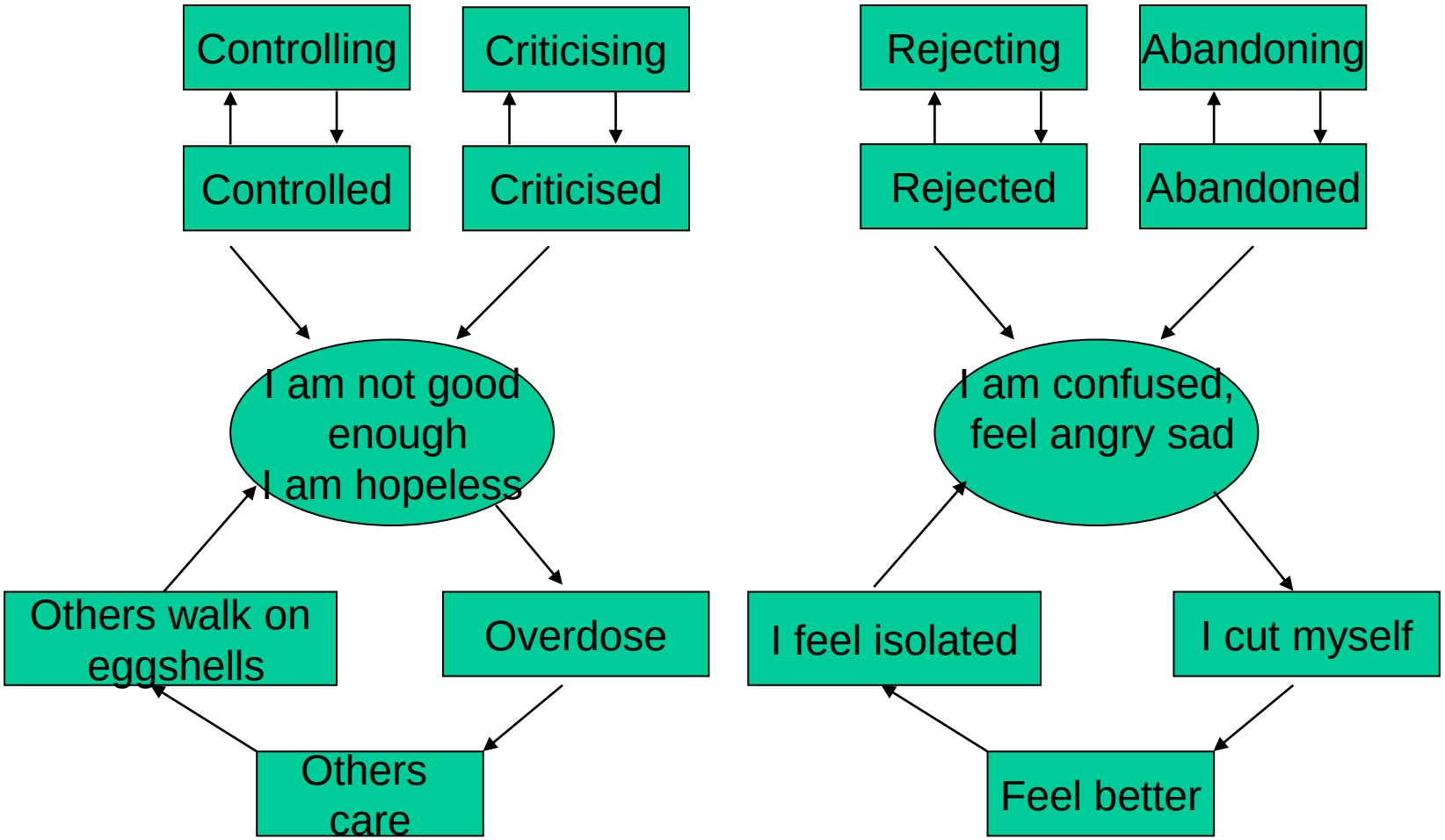
TA DIAGRAM COMPONENTS: CORE PAIN

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



TA DIAGRAM COMPONENETS: PROCEDURES

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

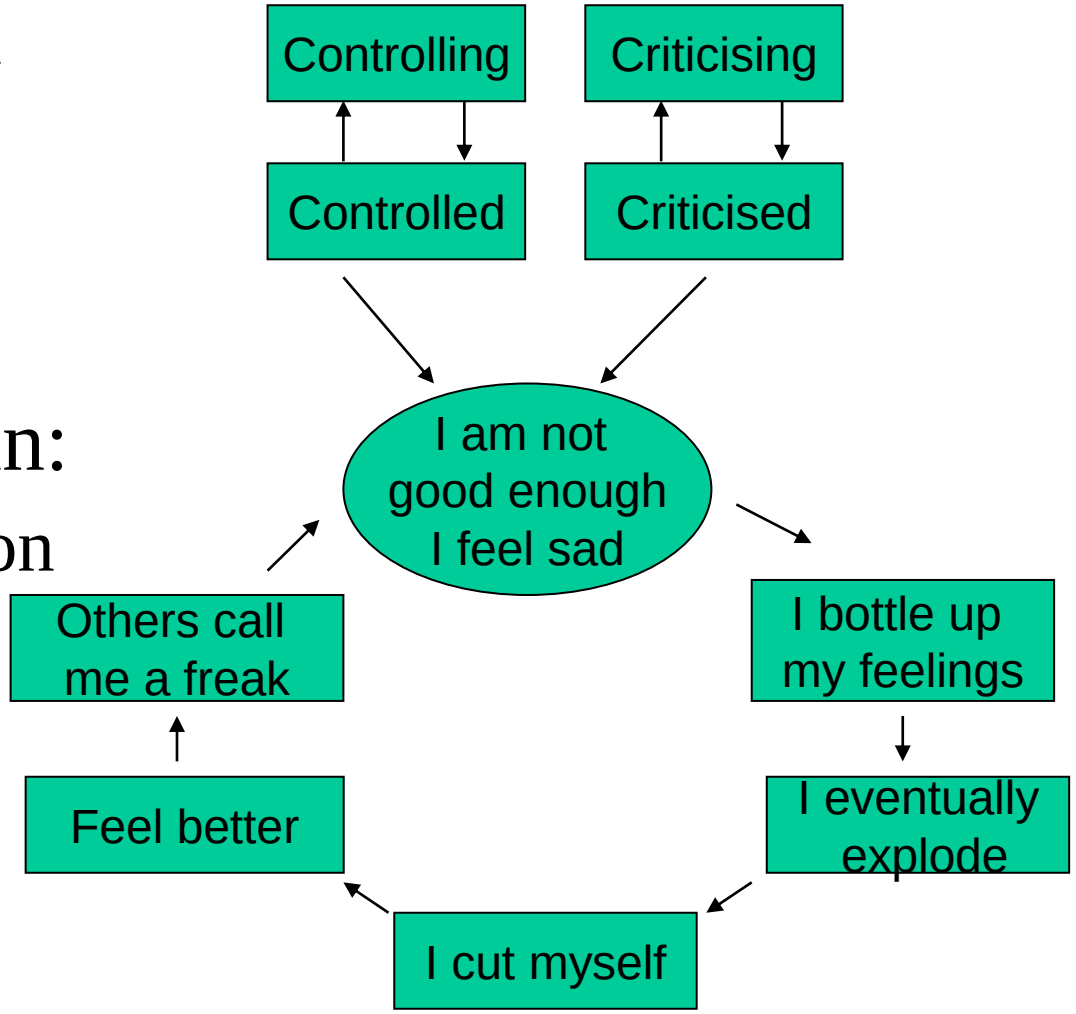


Self-harm usually occurs when other procedures fail to bring about relief

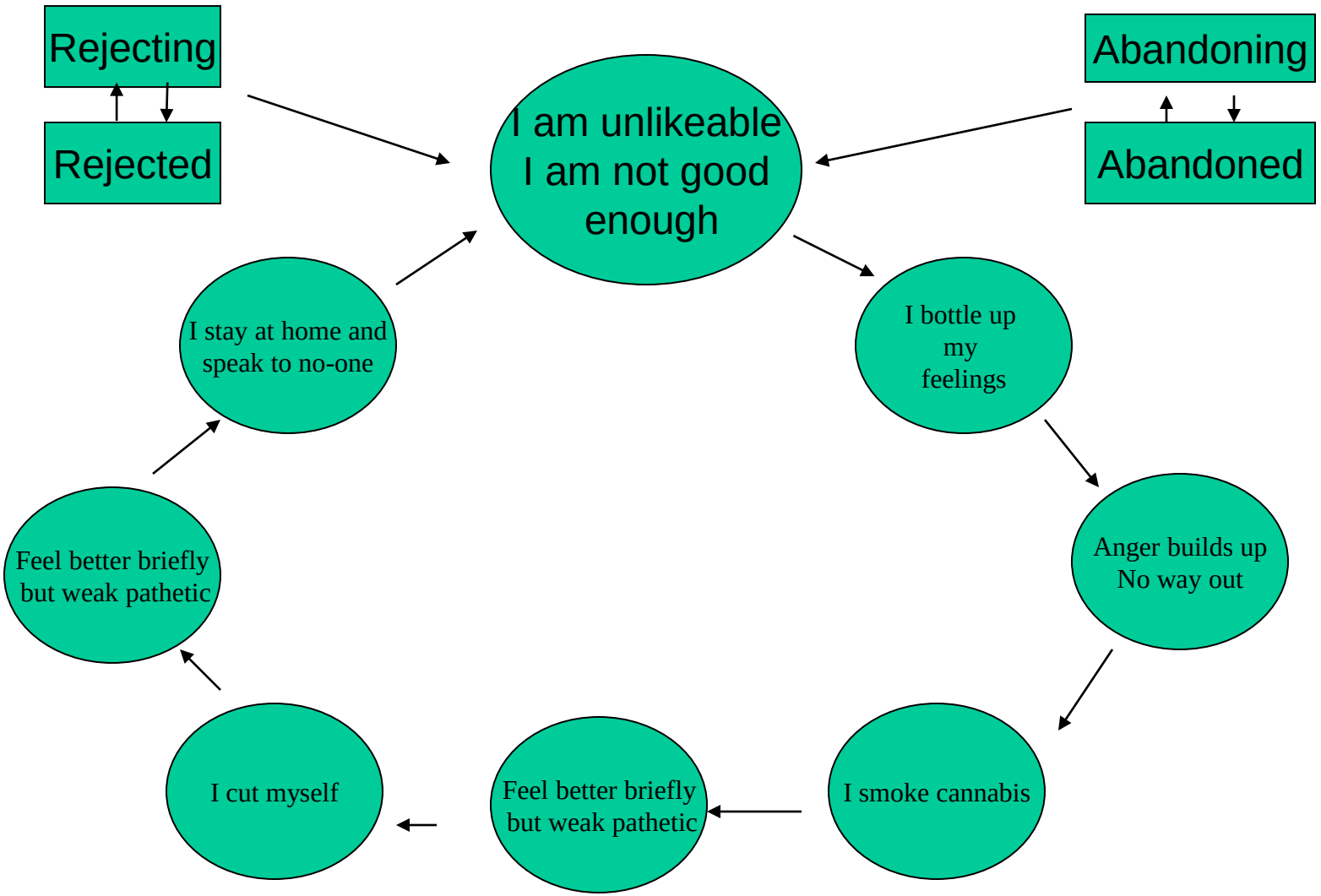
- Most frequently encountered behaviours designed to counter core pain:
  - Alcohol/drug use
  - Disordered eating
  - Fights
  - Perfectionism
  - Careless risk taking

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

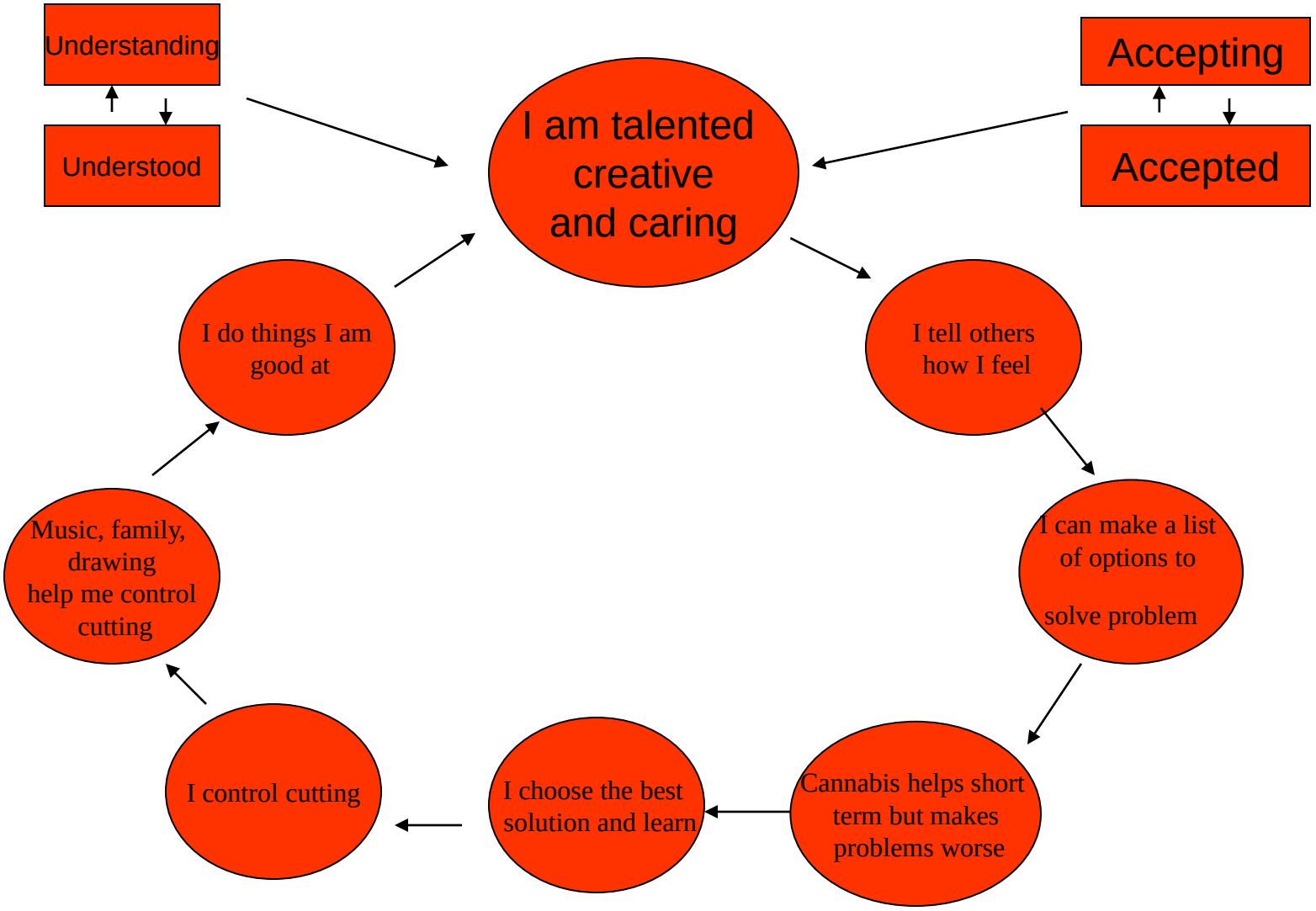
- Most frequently encountered cognitions designed to counter core pain:
  - Thought/emotion suppression
  - Rumination
  - Perfectionism



TA diagram


Rejecting
Rejected
Abandoning
Abandoned
I am unlikeable
I am not good enough
I bottle up my feelings
Anger builds up
No way out
I smoke cannabis
Feel better briefly but weak pathetic
I cut myself
Feel better briefly but weak pathetic
I stay at home and speak to no-one

TA Diagram with exits



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?